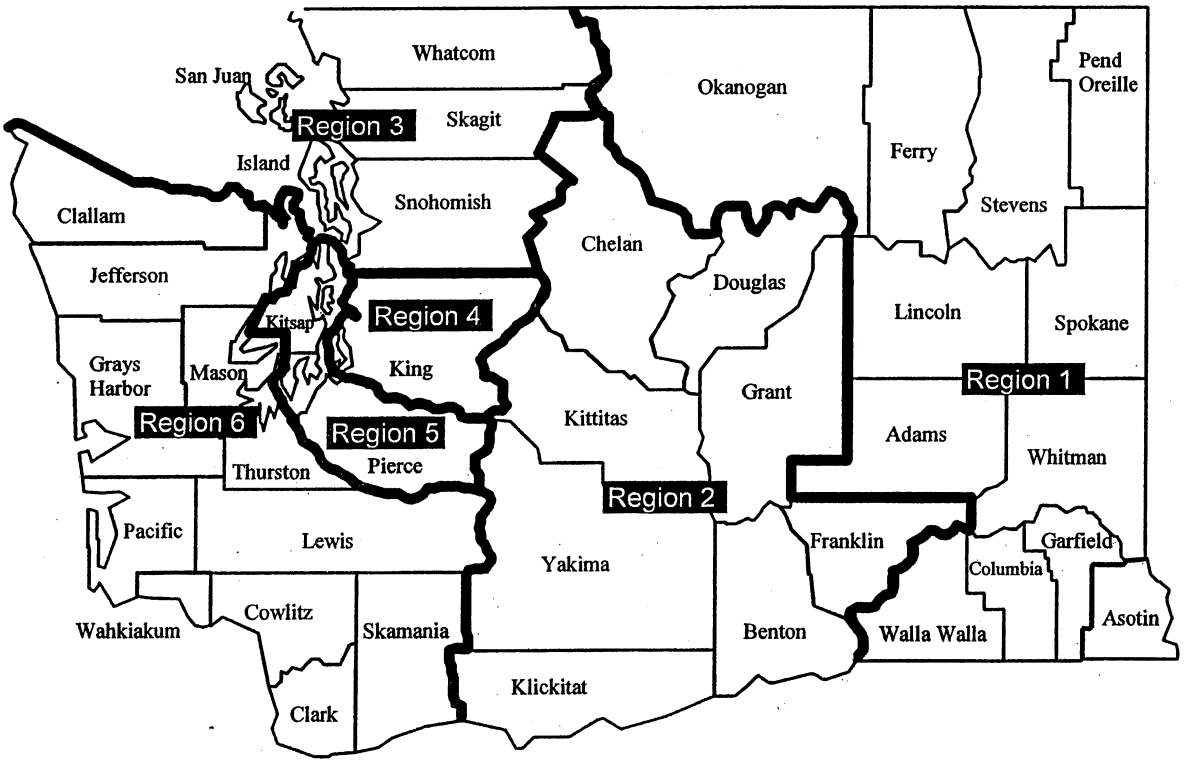
WASHINGTON STATE 2002-2003 HIV PREVENTION PLAN

2003 UPDATE



2003 UPDATE
WASHINGTON STATE HIV PREVENTION PLAN 2002-2003

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PURPOSE OF THE 2002-2003 WASHINGTON STATE HIV PREVENTION PLAN

The 2002-2003 Washington State Prevention Plan is a compilation of the six regional HIV plans and the planning provided by the Washington State HIV Prevention Planning Group. This plan provides the following:

1. Priorities and recommendations for HIV prevention throughout the state;
2. An overview of the planning process and HIV prevention efforts in the state;
3. A report to the community on the efforts of the many people involved in the planning process on a statewide basis;
4. A document to support the linkage and collaborations necessary to assure funding, services and other prevention efforts throughout the state; and
5. Meeting the requirements for community planning under the cooperative agreement with the Centers for Disease Control and Prevention (CDC) for federal prevention funding in the state.

2003 UPDATE Format:

The original 2002-2003 Washington State HIV Prevention Plan is the basis for this **2003 UPDATE**. Where new information has been added, the "new" material is lightly highlighted or otherwise clearly identified. Many sections have been completely revised and only the heading will be highlighted/identified. Small formatting, spelling, grammar or clarifying changes are not indicated. In some tables, new information is bolded to indicate changes from previous information, but the entire table is clearly identified as updated.

There are two sets of attachments associated with this **2003 UPDATE**. There are those attachments directly associated with the UPDATE (first set) and the attachments from the original 2002-2003 Plan, Attachment 6 of 2003 UPDATE. Every effort has been made to identify the location of the cited attachment.

2003 UPDATE - INTRODUCTION

This 2003 Update represents the planning efforts for the second year of the Washington State HIV Prevention Plan. While the planning cycles of the seven regional planning groups vary, all material presented in the state plan summarizes the statewide planning process as an UPDATE. Update information will be highlighted (lightly shaded) in the text, as needed, or clearly identified as 2003 updated material. Non-highlighted or identified can be considered to be original text or intent of the original 2002-2003 HIV Prevention Plan. (See note on PURPOSE, Page iii, for more details.

2002 INTRODUCTION

HIV has touched the lives of almost everyone living on the planet. No other public health issue has had such a far reaching and devastating impact on the social, economic, medical or spiritual lives of so many. In developing countries, HIV is clearly a sexually transmitted disease striking men, women and their children with painful loss. In the United States, HIV found its way into groups of people who practiced behaviors that put them at high risk for transmitting the virus; men who had unprotected anal sex with other men and people who used intravenous drugs. There was an epidemic of heroin addiction and intravenous drug use (IDU) with many patterns of needle sharing. The resulting transmission of HIV was, therefore, seen primarily in gay men and IV drug users and the early cases were, therefore, associated primarily with these behaviors. Therefore, people thought that AIDS was limited to these "risk groups."

Much of society believed that people who were gay or used illegal drugs by injection were immoral and/or criminal. The growing numbers of sick and dying were more often attacked and shunned than supported. When the numbers grew at alarming rates and public health officials began to talk about the 'epidemic,' there was an immediate clash between the politics and the prevention of HIV. Some public officials and commentators talked about innocent victims and "those who deserved it." Public health officials tried to apply standard disease and prevention methods, only to find that those methods were often seen as an infringement of the civil rights of those involved. Instead of being handled as a health problem, HIV moved from the public health arena to the political.

By the mid-1980's, technologies had been developed to identify the HIV antibodies in the blood. Transmission of HIV through blood transfusions rapidly decreased. By the late 1980's, the other blood products (such as Factor 8 for hemophiliacs) were also being screened. With the screening of blood and blood products, about the only way that HIV was transmitted from one person to another was through sharing of needles, unprotected sexual intercourse and to unborn or nursing babies of HIV positive women.
Because most of the HIV infections were still found primarily in gay men and injecting drug users, almost any intervention suggested met with resistance from either the public or the affected community. [For example: distribution of condoms with targeted, specific messages for gay men were considered to be condoning "immoral" or "perverted" behavior lifestyles or outside of general community norms and values.] Many materials and projects could not be funded with federal prevention dollars and were, therefore, not

available. An example for injecting drug users: If an HIV positive drug user shares a needle for drug use, HIV can be transmitted. Logically that means that supplying the person with a clean needle would reduce the risk of HIV transmission. This concept resulted in the needle exchange programs to provide clean needles. Because many people viewed this approach as contrary to the 'war on drugs,' federal funds were restricted from this intervention. Many communities, with other available funds, have started needle exchanges, but it is still very controversial and is, still, a prohibited activity through use of federal funds.

The first case of AIDS was reported in Washington State in 1982. In 1988, the Washington State legislature established the AIDS Omnibus Act. This Act defined the HIV prevention services that the local health jurisdictions were required to provide. It also divided the state into six AIDS service regions or networks (AIDSNETs). Most of the regions established a variety of internal planning, advisory and contracting processes. With the Omnibus legislation, there was a commitment of state dollars for prevention and some care efforts.

In 1993, the CDC community planning requirements were released which formalized community planning. The Washington State HIV Prevention Planning Group (SPG) was established and community participation at the regional level expanded. For the first four years, inclusion of regional and AIDSNET representatives on the SPG, coordination of regional efforts and state planning was attempted. However, there were fundamental issues (regional and state perspectives) that kept this effort from being successful. In October 1997, in Ellensburg, WA, a retreat brought together the SPG, regional planning groups, AIDSNET directors and coordinators, and Department of Health staff to review what was working in the planning process, what needed to be changed, and how the elements could be integrated. The result of this process was a document outlining the roles and responsibilities of the four groups, known as the Ellensburg Document. (see Attachment 1 – 2002-2003 Plan, Attachment 6, 2003 UPDATE)

Under the agreed roles and responsibilities from this process, the SPG establishes the procedures (guidance) for completing the planning processes. The regional planning groups (RPG) establish the priorities for the prevention efforts at the regional level. The SPG has the additional responsibility for the prioritization of the set-aside CDC resources that are used for statewide projects, activities, and interventions. Because of the wide range of timelines and processes in the regional planning process, previous state plans have included enormous quantities of text and materials.

The goal in the 2002-2003 Washington State HIV Prevention Plan is designed to capture all of this information in a single document, the Washington State HIV Prevention Plan.

Under the guidance and requirements of the CDC, the community planning process and the resulting plan must contain the following information:

The Basic Steps of the Planning Process

1. Epidemiologic (Epi) Profile

In order to assess the size and affect of the HIV epidemic in your area, an Epi Profile is developed by either the local health jurisdiction or Department of Health (DOH) assessment office. This Epi Profile will contain the important statistical and supplemental information needed to develop a portrait of the epidemic over the years and the populations at-risk in Washington State. This information will be gathered from a wide range of sources including disease reporting, surveillance, interviews, focus groups, surveys, community hearing and meetings, other related statistical information and markers, and local, statewide and national reports. An expert in the field of epidemiology and assessment will facilitate presentation and discussion of this information.

2. Community Resource Inventory (CRI)

Each planning group will compile a community resource inventory. This information may be generated through the SHARE (Statewide HIV Activity, Reporting and Evaluation) data collection system for those interventions funded through targeted CDC or Omnibus funds. For other resources, it is common for planning groups to survey the service providers. Regardless of the source of the information, the CRI should answer the question: "Who is doing what, for whom, in HIV prevention and how are those services delivered?" A final question may be: "At what cost?"

3. Gap Analysis

Each planning group must be able to clearly define the ***needs*** (needs assessment) of the at-risk populations in their region. Using the information collected about the ***resources*** available to meet their needs, the planning groups can determine those needs that are not being met. Through a decision making process, the ***unmet needs*** can be prioritized and effective interventions can be identified. Analysis of the differences between the present use of resources and the priorities may identify gaps in services. This analysis may result in a shift in resources to fill identified gaps.

4. Effective Interventions

Each planning group must determine a prioritized list of effective interventions for the at-risk populations. These interventions should be scientifically and behaviorally proven to meet the needs of the population served and result in changes that reduce the transmission of HIV. If no proven interventions are known or deemed appropriate, then unproven programs can be used if there is a strong commitment to evaluation of effectiveness. When the HIV prevention plan is written, it must cite the reasons why a particular intervention will work among the identified population.

5. Priority Setting

Using the Epi Profile and other supporting information, each planning group will set the priorities for HIV prevention in the region. The priorities and gap analysis will establish those needs and interventions that should be supported by available resources. Final funding decisions are made by DOH, with the budgets of the AIDSNETs, local health jurisdictions (LHJs), and the contractual formulae.

6. Writing the Plan
Putting it all together. Each planning group is responsible for approving the final written document, the *HIV Prevention Plan* for each region. Members of the planning group, support staff or other identified people may have written this document, but the final plan must be the product of an approval process by the entire group. Once the regional plan is complete, these regional plans are compiled and a statewide plan is developed by DOH. This statewide plan is approved by the SPG. This state plan becomes the basis for submission of the CDC application.

7. Evaluation
Each year planning groups must evaluate the planning process to suggest ways to improve the process in the following year.

8. Concurrence
Each planning group must determine the degree of congruence (match) between the priorities established in the prevention plan and the allocations established by DOH or the AIDSNET/LHJ. A letter from the planning group to DOH indicating the degree of concurrence or non-concurrence is submitted with each regional HIV prevention plan.

This plan will, therefore, outline and summarize all of the above steps for the six regional and the state planning groups.

For more information on CDC, community planning and/or HIV/AIDS, please call the Washington State HIV/AIDS Hotline at 1-800-272-2437 or the National HIV Hotline at 1-800-342-2437. For access on the Web, go to www.doh.wa.gov/cfh/hiv.htm for the Washington website and www.cdc.gov/hiv/dhap.htm for CDC, Division of HIV/AIDS Prevention

2003 UPDATE
All of the regional planning groups have focused on refining or implementing the prioritization process. Additionally, the AIDSNET coordinators had the opportunity to review the national CDC Community Planning Evaluation Workgroup materials. Washington State has been a participant on the workgroup since it's inception and was a pilot site for the retrospective evaluation study by the CDC. In order to incorporate the plan format guidance, regional plan review guidance and the draft features recommended by the workgroup, the Coordinators developed an integrated guidance (Attachment 1 of 2003 UPDATE). All planning groups utilized this guidance in developing the new or updated regional plans. This effort is contributing to the on-going endeavor to expand evaluation activities and to provide guidance and support for consistent planning in all regions. These activities further illustrate the commitment of the regions to actively participate in the community planning process.

WHO

WE

ARE

WASHINGTON STATE

Washington State is number 15th in total population, 19th in cases of AIDS, and 27th in the level of CDC funding. The first case of AIDS was reported in 1982 and there are a total of 9921 cases of AIDS reported in the state, as of 12/31/01. The general demographics of Washington are as follows:

TABLE 1 – General Demographics of Washington State, with Comparison between 1990 and 2000 Census

	1990 Census	2000 Census	
Total population, Washington State	4,866,692*	5,894,121**	
Gender			
Female	2,452,945 (50%)	2,959,821 (50%)	
Male	2,413,747 (50%)	2,934,300 (50%)	
Race/Ethnicity		Alone	Alone or in combo
White	4,411,525(91%)	4,821,823 (82%)	5,003,180 (85%)
Black	152,530 (3%)	190,267 (3%)	238,398 (4%)
Asian/Pacific Islander	215,411 (4%)	346,288 (6%)	438,502 (7%)
American Indian/Alaska Native	87,226 (2%)	93,301 (2%)	158,940 (3%)
Other	-	228,923 (4%)	287,400 (5%)
More than one race	-	213,519 (4%)	-
Hispanic ethnicity (any race)	214,489 (4%)	441,509 (8%)	
Age			
<=14	1,079,962 (22%)	1,255,051 (21%)	
15-19	325,081 (7%)	427,968 (7%)	
20-24	353,638 (7%)	390,185 (7%)	
25-29	411,518 (8%)	403,652 (7%)	
30-39	868,361 (18%)	921,428 (16%)	
40-49	657,140 (14%)	945,360 (16%)	
50+	1,170,992 (24%)	1,550,477 (26%)	

*Population Estimates and Projections: Department of Social and Health Services, Washington State
Adjusted Population Estimates, April, 1999.
**U.S. Census Bureau, Profiles of General Demographic Characteristics, 2000 Census of Population and Housing, Washington State, May 2001.

The six regions, with lead agency listed first, are:

REGION 1: *Spokane Regional Health District*: Adams, Asotin, Columbia, Ferry, Garfield, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, and Whitman.

REGION 2: *Yakima Health District*: Benton, Chelan, Douglas, Franklin, Grant, Kittitas, Klickitat, and Yakima.

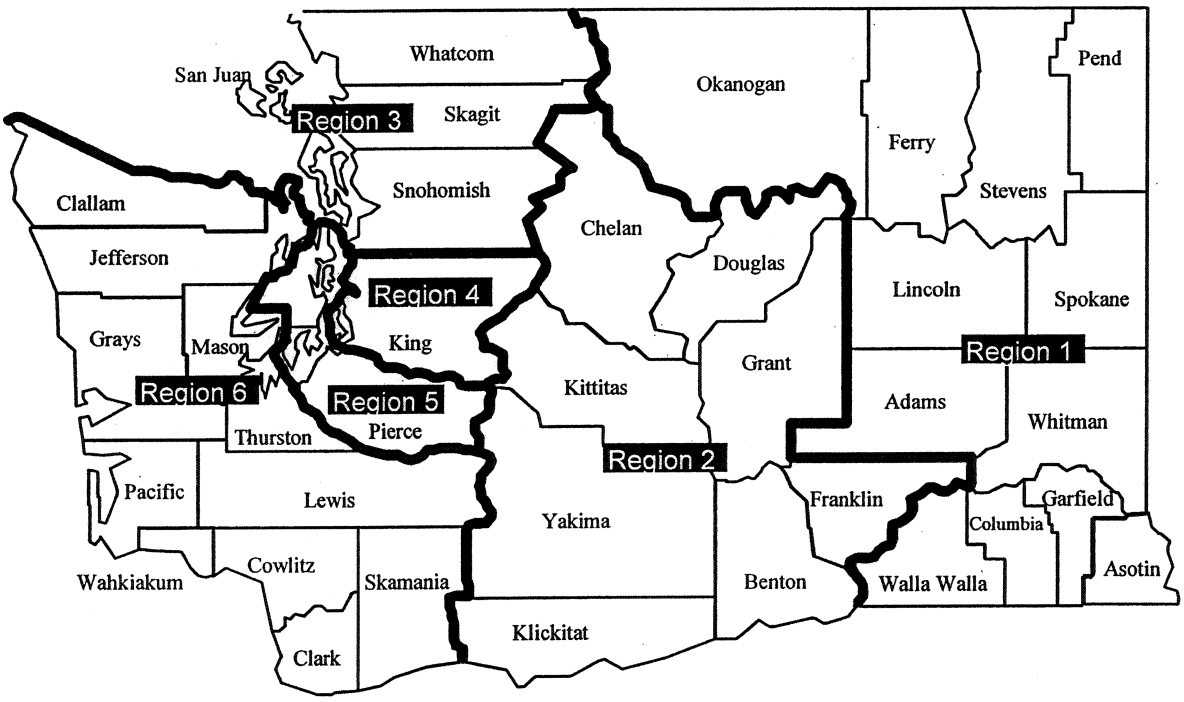
REGION 3: *Snohomish Health District*: Island, San Juan, Skagit, Snohomish and Whatcom.

REGION 4: *Public Health-Seattle & King County*: King.

REGION 5: *Tacoma-Pierce County Health Department*: Kitsap and Pierce.

REGION 6: *Southwest Washington Health District*: Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Lewis, Mason, Pacific, Skamania, Thurston and Wahkiakum.

FIGURE 1: Map of AIDSNET Regions, by County



Each of the six regions has an HIV Prevention Planning group (RPG). These planning groups are responsible for developing the Regional HIV Prevention Plan. Through their efforts, the demographics of HIV/AIDS in their respective areas are reviewed, needs are determined and priorities are established. Membership on the planning group is governed by the charter or by-laws of the group. All of the RPG's have membership committees that recruit and nominate new members, provide support for active members and review the membership. The number of members on each RPG varies with the by-law requirements and character of the region. Under guidance from CDC and the SPG, each RPG must have a Parity, Inclusion and Representation (PIR) Plan for recruiting, retaining, orienting and training. Each RPG selects three (3) members to represent the region on the State HIV Prevention Planning Group (SPG). It is requested that public health, community-based organizations and the infected/affected communities be represented by at least one member.

The State Planning Group (SPG) consists of 30 members (with 2 additional slots available to meet the recommendations of the PIR plan). Eighteen (18) of the members are appointed by the RPG's and twelve (12) members are nominated by the SPG Membership Committee and appointed by the Washington State Department of Health (DOH). These 12 at-large members may be selected to provide technical knowledge, population or geographic parity (balance) or services representation. Table 2, 3 and 4 summarize the demographics, membership representation and expertise found on each of the planning groups.

2003 UPDATE – Membership Profiles - Demographics
Membership on both the SPG and the Regional Planning Groups was down slightly in 2002. Because representation on many of the planning groups has been relatively stable over the past several years, the age of the membership has increased. There has been little success in recruiting or retaining younger planning group members. Youth issues, however, have been clearly addressed by all planning groups through representation from youth services agencies, youth advocates and the priority decisions that target youth. The loss of several homosexual representatives to death or illness during the past year is definitely reflected in the profile. A majority of the changes in the 2003 profile, however, is due to the redefinition and restructuring of the membership profile itself. This is the first year that all of the membership statistics were reported on the 2002 CDC Membership Profile form. This greatly influenced the final categories and numbers, especially in the HIV Risk Category, Geographic Location and Ethnic/Racial data.

TABLE 2 – 2003 UPDATED
MEMBER PROFILE DATA COMPARISON – AS OF 7/1/02

		Epi data	SPG		Regional Total	
		Percent %	Number	Percent	Number	Percent
AGE:	</= 19	9	0	0	0	0
	20-24		0	0	0	0
	25-29	65	0	0	8	7
	30-49		13	52	84	69
	50 and over	26	12	48	38	22
GENDER:	Male	90	17	68	58	47
	Female	10	8	32	63	51
	Transgender	-	0	0	2	2
SEXUAL	Bisexual	-	1	1	9	7
ORIENTATION:	Heterosexual	7	9	36	53	43
	Homosexual	63	11	44	38	31
	Unknown	-	4	15	23	19
GEOGRAPHIC	Urban	-	9	36	33	28
LOCATION:	Mid-size	-	13	52	48	40
	Rural	-	3	12	38	32
ETHNICITY:	Hispanic	9	1	4	10	8
	Not Hispanic		24	96	113	92
RACE:	Amer Indian/ Alaskan Native	2	0	0	5	4
	Asian	2	0	0	0	0
	Black/Afr Amer	12	2	8	11	9
	Nat Hawaiian/ Pacific Islander	-	0	0	1	1
	White	84	21	84	105	85
	< one race	-	2	8	6	5
HIV RISK	MSM	65	8	32	33	27
CATEGORY	IDU	10	2	8	5	4
	MSM/IDU	10	2	8	5	4
	Hetero at risk	6	2	8	13	11
	Gen Population	*	11	44	67	54
TOTAL NUMBER OF MEMBERS			25		123	

*Eighteen (18) members of the State Planning Group are also members of a Regional Planning Group

TABLE 3 – 2003 UPDATED
PLANNING GROUP MEMBERSHIP BY GOVERNMENTAL AND NON-GOVERNMENTAL REPRESENTATION

PRIMARY REPRESENTATION	SPG	Regional
MEMBERS FROM GOVERNMENTAL AGENCIES		
State Health Department	3	3
Local Health Department(s)	4	39
Education Agencies	2	2
Correction Agencies	1	0
Mental Health Agencies	0	1
Substance Abuse Agencies	1	1
Youth Agencies	0	0
Other Governmental Agencies	0	3
Total Government Members-Primary	11	49
NON-GOVERNMENTAL MEMBERS		
Community-based Organization -Non-minority Board	7	34
Community-based Organization – Minority Board	1	4
Faith Organization	0	7
Academic Institutions	0	2
Research Center	0	0
Other Non-Profit	0	2
Individual person representing ethnic, racial and risk populations	3	16
Other advocate and youth	3	9
Total Non-Governmental Members-Primary	14	74
SECONDARY REPRESENTATION		
MEMBERS FROM GOVERNMENTAL AGENCIES		
State Health Department	0	0
Local Health Department(s)	1	0
Education Agencies	1	1
Correction Agencies	0	0
Mental Health Agencies	0	1
Substance Abuse Agencies	1	1
Youth Agencies	0	1
Other Governmental Agencies	0	1
Total Government Members - Secondary	3	5
NON-GOVERNMENTAL MEMBERS		
Community-based Organization -Non-minority Board	1	0
Community-based Organization – Minority Board	0	3
Faith Organization	0	2
Academic Institutions	0	2
Research Center	0	0
Other Non-Profit	0	3
Individual person representing IDU, HIV+	2	2
Other advocates, youth	2	3
Total Non-Governmental Members-Secondary	5	15

2003 UPDATE – Membership Profiles – Affiliations

The percentage of members who work in health departments increased. There has been a trend over the past few years, as people with HIV are more able to work, that many of the community representatives have taken full or part time jobs with local health departments. This is reflected, especially in the regional planning groups, by the large number of people who identify as community representative in their secondary representation. PIR plans in each of the regions reflect their efforts to recruit and retain members from a variety of governmental and non-governmental agencies and organizations.

Table 4: 2003 UPDATED
EXPERTISE REPRESENTED ON PLANNING GROUPS

PRIMARY EXPERTISE CATEGORY	SPG	Regional
Epidemiologist	1	2
Behavioral/Social Scientist	2	10
Health Planner	2	10
Evaluation Researcher	1	3
Intervention Specialist	4	14
Community Representative	8	75
Other Care, Education, PH Admin, Community Activism, Medical Research, STD Prevention, Human Services	7	9
Total Members/Expertise (must equal total membership)	**25**	**123**
SECONDARY EXPERTISE CATEGORY		
Epidemiologist	0	13
Behavioral/Social Scientist	3	12
Health Planner	4	10
Evaluation Researcher	1	8
Intervention Specialist	4	22
Community Representative	2	17
Other Incarcerated, Global AIDS	2	3
Total Members/Expertise (will not equal total membership)	**16**	**85**

2003 UPDATE – Membership Profile – Expertise

This entire table was updated due to the changes in definitions and categorization on the 2002 CDC Membership Profile.

Each of the groups has an appointed health department co-chair and an elected community co-chair. Some groups also have an elected community vice-chair who will assume the duties of co-chair at the beginning of the next planning year. Most planning groups have a planning calendar that begins in October and ends in September. The following is a list of Health Department and Community Co-chairs:

UPDATED: WASHINGTON STATE HIV PREVENTION PLANNING CO-CHAIRS - 2002 PLANNING YEAR (2003 Plan)

REGION 1: (Eastern)

Health Department Co-chair
Barry Hilt
Region 1 AIDSNET Coordinator

Community Co-chair
Muril Demory
Community Member

REGION 2: (Central)

Health Department Co-chair:
Wendy Doescher
Region 2 AIDSNET Coordinator
Yakima Health District

Community Co-chair
Debra Severtson-Coffin
Community Member

REGION 3: (Northwest)

Health Department Co-chair:
Ward Hinds, M.D.
Health Officer
Snohomish Health District

Community Co-chair
Stephen Dorn
Community Member

REGION 4: (Metro Seattle-King County)

Health Department Co-chair
Dr. Bob Wood, M.D.
AIDS Control Officer
Public Health - Seattle & King Co.

Community Co-chair
Sam Soriano
Community Member

REGION 5: (Pierce/Kitsap County)

Pierce County:

Health Department Co-chair:
Charles Fann
Tacoma-Pierce Co. Health Department

Community Co-chair
Howard Russell
Community Member/CBO

Community Vice-chair
Porsha Robinson
Community Member

Kitsap County

Health Department Co-chair:
Lenore Morrey
Bremerton-Kitsap Health District

Community Co-chair
Michael Karpin
Community Member

REGION 6: (Southwest)

Health Department Co-chair:
David Heal
Region 6 AIDSNET Coordinator
SW Washington Health District

Community Co-chair
Clain Lust
Community Member

STATE PLANNING GROUP

Health Department Co-chair:
Jack Jourden, Director, IDRH
WA State Department of Health

Community Co-chair
Dale Briese
Spokane AIDS Network – Region 1

Community Vice-chair
James Minahan
Community Member – At-Large

In establishing the process of community planning, the CDC clearly considered that PIR (Parity, Inclusion and Representation) was an absolute goal and requirement. Two of the five national objectives for community planning are:

1. **Foster the openness and participatory nature of the community planning process.**

2. **Ensure that the CPG(s) reflects the diversity of the epidemic in your jurisdiction and that expertise in epidemiology; behavioral science, health planning, and evaluation are included in the process.** (Quoted from CDC Guidance)

2003 UPDATE

All of the planning groups have developed and, at least partially, implemented their PIR Plans. Some major achievements over the past 2 years have included:

1. More involvement of people of color on regional planning groups. (+5%)
2. Representation of the transgender community on the Region 4 planning group and subcommittees.
3. Increased numbers of HIV infected members. (+5%)
4. Membership has remained very stable. On many groups, including the SPG, a majority of members have served for at least 2 years.
5. Several planning groups have been able to have youth representation, but none stayed long enough to be reflected in the Membership Profile.

The unmet membership needs are:

1. Recruiting and retaining members from the Asian and Pacific Islander communities.
2. Representation of corrections and mental health services on the regional planning groups.
3. Representation from youth and young adult, especially MSM, community.

Each planning group will continue to monitor the PIR plan and develop strategies to fill any gaps that might exist in representative membership.

All planning groups have a variety of strategies to recruit new members. The SPG developed a booklet called "The Little Blue Book" (Attachment 7 of 2002-2003 Plan, Attachment 6, 2003 UPDATE) that outlines the community planning process. This booklet can be used to inform prospective members of the planning process. All of the planning groups use word-of-mouth to recruit new members. Additionally, identified community leaders and experts may be directly recruited. Most planning groups place ads in local newspapers, newsletters and other media to advertise their meetings. Many groups distribute fliers and posters to invite people to come to meetings or join the group.

All meetings of the planning groups are open to the public and are ADA (Americans with Disabilities Act) accessible. All groups can provide ADA accommodation with sufficient notice. All groups support the attendance of their membership by providing reimbursement for mileage and other related expenses. If large distances are involved in attendance, airfare and lodging are also provided. Childcare and other related costs may also be reimbursed.

Each of the planning groups has a charter or by-laws that govern membership and process. All of the by-laws: 1) establish a membership committee; 2) define conflict of interest and how to deal with it; and, 3) define how decisions are to be made by the group (most rely upon consensus). Most of the planning groups have written procedures for: 1) conflict resolution; 2) maintenance of confidentiality; 3) establishment of committees/ subcommittees; and, 4) ground rules for meetings. All groups establish a planning calendar each year.

Every planning group has discussed and developed a Parity, Inclusion and Representation (PIR) Plan on how to make sure that the planning process is available and accessible to those communities impacted by HIV. This might include availability of translators, moving the meeting place around a region, having meetings at different times of the day or week and holding special meeting on more convenient days or in more convenient locations.

Communication between the SPG and the RPG's is facilitated by the RPG representatives on the SPG. It is their role to bring information to the SPG about their respective regions and to take information back to their RPG on decisions and guidance developed at the

SPG. Additionally, a staff member from DOH is often present at the regional meetings to provide technical assistance and clarification of information or process.

DOH HIV Prevention and Education Services publish a quarterly newsletter, *Washington State Responds (WSR)*. *WSR* informs and educates stakeholders and the public on HIV and other infectious disease and reproductive health topics. Each edition of *WSR* features information on surveillance data, STD, TB, Family Planning and other related public health issues. Updates on the community planning process and feature articles on prevention are also included. This publication is mailed to over 1500 people in the state. Additional information on community planning is also available on the HIV Prevention and Education website at www.doh.wa.gov/cfh/hiv/htm.

2003 UPDATE
All of the planning groups have at least one new member orientation session per year. Most of the planning groups have implemented a subcommittee process that involves additional community or agency people, not just group members. All of the planning groups and their plans have indicated what membership gaps presently exist. Universally, planning groups have expressed concern in recruiting and retaining younger members, IDU's and people of color.

WHAT

WE

DECIDED

WHAT WE DECIDED

BEHAVIORAL RISK CATEGORIES

The State Planning Group (SPG) is responsible for determining the priority order of the Behavioral Risk Categories. These reflect the statewide picture and are for guidance to the regional groups. The Behavioral Risk Category priorities are:

1. MSM – Men who have sex with men
The behavioral risk category includes all behaviors that involve sexual activities between men. Such behaviors include anal and oral intercourse. Specific behaviors that might increase the risk of HIV transmission could include unprotected anal or oral sex (not using a condom), multiple or anonymous partners of unknown serostatus, and sharing of sex 'toys,' Whether the person identifies as gay, bisexual, heterosexual or other sexual identity, if he participates in sexual activity with other men, he fits in this category.

2. IDU – Injection Drug User
The behavioral risk category includes all behaviors associated with injecting legal and illegal substances intravenously, intramuscularly or subcutaneously. The primary risk for HIV transmission is from sharing the injection equipment with another person, who is HIV+.

3. HETEROSEXUAL (HET)
This behavioral risk category includes all behaviors that involve sexual intercourse between male and female partners. Such behaviors include unprotected anal, vaginal and oral intercourse. The highest risk behaviors involve unprotected sex with sero-positive or at-risk partners.

NOT PRIORITIZED – PREGNANT WOMEN
The SPG also determined that perinatal transmission of HIV from HIV+ mothers to their unborn and infant children is not a behavioral risk category to be addressed in the state plan. While perinatal transmission is a concern, the prevention of this transmission is clearly a treatment issue. It is recommended that perinatal HIV testing be available and encouraged as a prevention strategy for pregnant women. To this end, the SPG has endorsed the recommendations of the Maternal/Child Health Consumer Advisory Group to change state rules to allow HIV testing of pregnant women to be part of a standard screening test panel, unless the woman specifically refuses the HIV antibody test. Public input on this rule change is presently being taken and is generally supportive.

2003 UPDATE
In April, 2002, the SPG reviewed the prioritized risk categories and identified HIV+ individuals, within each category, as populations to be considered. Even though HIV+ is not a behavioral risk category, the SPG determined that targeting HIV+ individuals for high risk behaviors was of great significance. HIV+ was identified as the first priority for all risk behaviors resulting in the following prioritized list of risk categories:

1. HIV+ persons and their partners
2. MSM
3. IDU
4. Heterosexuals at risk

Pregnant women – not prioritized

HIV+ and their partners:
This prioritized category includes persons, regardless of behavioral risk category, who are infected with HIV and their sexual or needle sharing parties.

Pregnant Women:
On 7/6/02, the rule encouraging adding the HIV Anti-body Test to the panel of perinatal tests took effect.

The regional planning groups have ranked the behavioral risk categories as follows:

TABLE 5 – 2003 UPDATE
Rank Order of Behavioral Risk Categories by Planning Group (Changes in bold)

CPG→	Region 1	Region 2	Region 3	Region 4	Region 5-Kitsap*	Region 5-Pierce*	Region 6
HIV+	**HIV+**					**HIV+**	
MSM	MSM	MSM	MSM	MSM	MSM	**MSM**	IDU
IDU	IDU	**IDU**	IDU	**HET**	IDU	**IDU**	MSM
HET	HET	**HET**	HET	**IDU**	HET	HET	HET
				Transgender			

*Region 5 has 2 separate community planning groups (CPG) in Kitsap and Pierce Co.

2003 UPDATE
Region 1 has determined that HIV+ are critical in all risk categories and has, tentatively, considered them as a separate category. A final prioritization decision will be made in the next planning cycle. Region 2 determined that the epidemiologic data supports the prioritization of IDU as second, but is still discussing the issues that also support the emphasis on heterosexuals as an emerging category. The prioritization decision in Region 4 was also based on an emphasis on heterosexual as the emerging issue. The actual categorization was close to a tie between heterosexuals and IDUs. Region 5 – Pierce Co. reprioritized their behavioral risk categories and the final prioritization more closely reflected the epidemiologic data. The decision in Region 6 to rank IDU above MSM was based on discussion of the riskiness of behavior and the strong belief by the planning group that IDU's were the highest priority in the region.

TABLE 5a: Target Populations by Regions 2003 UPDATE

All planning groups discussed and/or formally adopted behavioral based target populations for each of the risk categories. These behaviors are:

Unprotected anal intercourse – primarily MSM, MSM/IDU
Unprotected sexual intercourse – primarily HETEROSEXUALS
Sharing needles/paraphernalia – primarily IDU
Multiple sexual partners – all categories

As a result of these decisions and discussions the following priorities were set in the regional plans:

2003 PRIORITIZED POPULATIONS BY REGION

RANK	Region 1	Region 2	Region 3	Region 4	Region 5 – Kitsap	Region 5 – Pierce	Region 6
#1	**HIV+ and/or their partners who…** Have multiple sex partners Engage in unprotected sex Share needles	**MSM** HIV+ Non-self ID <24	**MSM** HIV+ Unprotected anal intercourse MSM/STD MSM/IDU	**MSM** HIV+ POC IDU HIV-/Unk status Youth	**MSM** Gay ID HIV+ <24 Non-gay ID IDU Methamphet	**HIV+** Latino/Latina	**IDU** HIV+ Female Inj. Homeless Inj. Incarcerated Inj Injectors MSM POC Youth Multiple sex partners

2003 PRIORITIZED POPULATIONS BY REGION – CONT.							
RANK	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5 – Kitsap**	**Region 5 – Pierce**	**Region 6**
#2	**MSM and their partners who…** Have multiple sex partners Engage in unprotected sex Share needles Including: HIV+ MSM/IDU POC Youth Migrants Persons in care Drug Tx Sex partners STD Non-gay ID Alcohol/drug	**IDU** HIV + Needle sharing	**IDU** HIV+ People who share needles	**Heterosexuals** Female sex partners of HIV+ or at-risk persons Males and females with STD's	**MSM/IDU** HIV+/partners Meth users Heroin users	**MSM** HIV+/partners African Amer MSM/IDU Latino Youth	**MSM** HIV+ persons BLGTQ*/youth HIV+ partner IDU Male POC Multiple sex partners Non-ID Survival Sex

*BLGTQ – bisexual, lesbian, gay, transgender and questioning people, usually associated with youth.

2003 PRIORITIZED POPULATIONS BY REGION – CONT.							
RANK	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5 – Kitsap**	**Region 5 – Pierce**	**Region 6**
#3	**IDU and their partners who…** Have multiple sex partners Engage in unprotected sex Share needles Including: HIV+ MSM Youth POC Incarcerated Migrant Drug Tx STD Sexual partner	**Heterosexuals** HIV+ Multiple sex partners Anal Sex	**Heterosexuals** HIV+ With STD Female with partner of unknown status	**IDU** Homeless/ involved in legal system Female/ survival sex <25 injector/ new injector HIV+/HCV+	**IDU** HIV+/partners Heroin User Meth user	**IDU** HIV+/partners Share needles African Amer Latino/a	**Heterosexual** HIV+ persons HIV+ partners Multiple sex partners POC Survival sex Female partners of IDU Female partners of MSM
#4				**Transgender**	**Heterosexual** HIV+ Partners of HIV+ Survival sex	**Heterosexuals** HIV+/partners African Amer females	

EFFECTIVE INTERVENTIONS

The SPG considered the possible effective interventions available in the scientific and behavioral literature for the various behavioral risk categories and potential subpopulations. Through review of the literature and discussion with our expert members and advisors, the effective interventions matrix, Table 9, was adopted (5/26/01). This matrix was developed to guide the regional planning groups in selection of effective interventions for their region. The intervention types listed in this matrix are prioritized for the general behavioral risk category.

TABLE 9 PRIORITIZED EFFECTIVE INTERVENTION TYPES BY BEHAVIORAL RISK CATEGORY

HIV+ /partners - Urban & Rural

	HERR	HC/PI	CTR/PCRS	PCM
1	Groups Individual Level		Targeted CTR PCRS "Person @risk"	PCM
2	Community Level Intervention (Communities of color)	Social Marketing Mass Media & Other Media		
3		Hotline/Clearinghouse		

MSM – Urban and Rural

	HERR	HC/PI	CTR/PCRS
1	Community-level Interventions Group-level Interventions		CTR-high risk PCRS
2	Street/Community Outreach Individual-level Interventions	Social Marketing Mass Media & Other Media	
3		Hotline/Clearinghouse	

IDU – Urban and Rural

	HERR	HC/PI	CTR/PCRS
1	Needle Exchange Community-level Interventions		CTR –high risk PCRS
2	Individual-level Interventions Street/Community Outreach		
3	Group-level Interventions	Mass Media & Other Media Social Marketing Hotline/Clearinghouse	

HETEROSEXUAL - Urban

	HERR	HC/PI	CTR/PCRS
1	Community-level Interventions Group-level Interventions Street/Community Outreach		CTR – high risk PCRS
2	Individual-level Interventions	Mass Media & Other Media Social Marketing	
3		Hotline/Clearinghouse	

	HERR	HC/PI	CTR/PCRS
	Community-level Interventions **Group-level Interventions**	**Mass Media & Other Media** **Social Marketing**	**CTR – high risk** **PCRS**
	Individual-level Interventions **Street/Community Outreach**		
		Hotline/Clearinghouse	

For a detailed definition of interventions, see pages 71-72 (2003 UPDATE)

2003 UPDATE

A committee of the SPG reviewed the "interventions-in-a-box" produced by the HAPPA project of Sociometrics, Inc. This committee also functioned as the DOH Materials Review Panel for these materials. The interventions were reviewed and recommendations made for their utilization as effective interventions for target population. The following projects were recommended:

Brother to Brother: GLI, African American Gay and Bisexual Men
Doing Something Different: GLI to promote condom use – all risk categories
Hot, Health & Keeping it Up: GLI, gay men of color
Let's Chat: GLI, heterosexuals
Point forPoint: Needle exchange for IDU
Project SMART: GLI, drug users
Safety Point: Active needle users
The SISTA Project: women

In addition to the recommendations, committees reviewed interventions for MSM, IDU, Heterosexuals and HIV+ and provided reports to the April SPG meeting. These reports provided recommendations of specific interventions that were reviewed by the committees. A copy of these reports can be found as Attachment 2, 2003 UPDATE.

For **ALL** Risk Categories and Populations, Counseling, Testing and Referral and Partner Counseling and Referral Services were recommended.

As part of the decision making process for Region 4, Public Health-Seattle & King County staff developed a review of the literature. This review was distributed to all planning groups and can be found as Attachment 2 of the 2002-2003 Plan, which is Attachment 6 of this 2003 UPDATE. It can also be accessed on the web at www.metrokc.gov/health/apu/intervention.

According to the Ellensburg Document, 10% of the CDC funding (of no less that $250,000 and no more than $400,000) are to be 'set-aside' for projects of statewide significance. It is the responsibility of the State Planning Group (SPG) to establish the priorities for use of these funds. The following is the priority list established by the SPG for 2003:

2003 UPDATE – TABLE 10
Washington State Priorities for CDC Set-Aside Resources

Proposed Uses of Statewide "Set-Aside" Funds	RANK	2002	2003
Use funds to continue technical assistance and training to the field for Friend to Friend Project	1	Funding to HAPDEU to continue technical assistance to F2F	Funding to HAPDEU to continue technical assistance to F2F
Needs Assessment – Young gay men of color-African Americans	2	RFP not developed because of insufficient funds	Propose doubling funding ($50,000) and issuing RFP in late 2002
Support new CT technologies – ORASURE	3	Doubled funding to provide regional ORASURE testing	Continue ORASURE funding at same level
Implement seasonal/ migrant farmworker intervention in response to needs assessment	4	Needs assessment will be completed in December 2002. Added $25,000 to the contract to assure relevant assessment	Plan and implement intervention
Rural IDU	5	Plan a consultation with rural providers to develop further planning	Develop report to provide guidance to regional planning groups to improve or implement services to rural IDU's
CARRY OVER PROJECTS			
Prevention Institute: Complete Training Needs Assessment Develop training plan		Completed in July 2002 Training plan will be developed and training calendar for 2002-2003 established by October 1, 2002	Continue with training plan and integration of prevention issues in any statewide conferences
Multi-year group-level intervention for incarcerated women		RFP issued and contract awarded for group-level intervention at the Washington Correction Center for Women	Continue the group-level intervention at WCCW
Development of Outcome Monitoring Tool		Technical assistance to develop Outcome Monitoring tool	Implement Outcome Monitoring for group and individual level interventions

Each planning group was surveyed to determine the types of technical assistance they believed was the most important. All planning groups responded with at least a list of needs, and several prioritized these needs. Based on this information, following are the recommendations for technical assistance:

Community Planning Group needs:

- Identification of effective rural interventions for target subpopulations
- Methods of determining subpopulations
- Clarification of the tools of community planning, including community resource inventory (CRI), cost effectiveness and gap analysis
- Recruiting and retaining infected/affected and communities of color members on the planning group
- Effective intervention and prevention technology updates
- Needs assessment data for subpopulations

Prevention needs:

- Effective interventions for rural populations
- Program evaluation and outcome monitoring
- Understanding of cultural barriers to HIV prevention

2003 UPDATE

COMMUNITY PLANNING GROUP NEEDS

Through the effective interventions review process, several rural programs have adopted/adapted scientifically proven interventions for their prioritized populations. Region 2 has implemented a Group Level Intervention (GLI) for needle exchange participants who exchange <25 needles. There are now waiting lists for these groups and several participants have asked if they can repeat the group. Initial assessment of the efficacy of this intervention in reaching the target population would have lead us to believe that it would not be popular, but actual fact indicates the opposite.

New guidance and manuals have been developed for Priority Population Needs Assessments (Attachment 3A and 3B, 2003 UPDATE). Between these materials and guidance from the Institutional Review Board that clarifies these activities as program evaluation rather than research, needs assessments will be more meaningful and possible than in the past. It is anticipated that, at a minimum, each region will provide a needs assessment of one of their prioritized populations.

Additionally, all of the planning groups are beginning to look at behavior-based populations. As these concepts becomes clearer, subpopulations that participate in the risk behaviors will become clearer and prioritization will be more specific. These will become more effective when outcome based interventions begin to be utilized.

The Community Resource Inventory for all interventions tracked through the SHARE system (all federally and state funded interventions) is included in this plan. Based on

these data, regions will be able to expand their CRI to include those programs that are not tracked in SHARE.

Guidance for the gap analysis has been issued and utilized in at least one region. As more needs assessment data is available, the utility of the gap analysis process should become more evident.

Cost effectiveness guidance will remain a need beyond this planning period. Washington is waiting for the outcome of several projects at CDC to develop useable computer models for cost effectiveness analysis. To try to develop our own system is well beyond the abilities of anyone presently working with or serving on the planning groups. This would not be a cost effective use of either resources or funds.

Annual review of effective intervention materials will be developed and presented to the planning groups.

PREVENTION NEEDS:

Consultation on effective interventions for rural IDU's will be a task for 2003.

Outcome monitoring tools for group and individual level interventions have been developed and will be implemented in 2003. These data should begin the process of program evaluation, modification and planning to assure that effective interventions are being provided.

Most planning groups have indicated that cultural competency will be an on-going topic at their meetings.

WHY WE MADE THE DECISIONS

2003 UPDATE - WHY WE MADE THE DECISIONS

The SPG received an epidemiology presentation in January 2002. This presentation, in addition to the regional presentations, updated the previous epi information for the 2002-2003 plan. (See Attachment 4, 2003 UPDATE - Draft 2002 Washington State Epidemiologic Profile) **This chapter of the 2003 Update contains the most recent information available and has been completely revised.**

The basis for all decision making for HIV prevention is the epidemiologic (epi) data. These data tell you:

- how many people have been infected or diagnosed with HIV/AIDS
- where they were diagnosed
- when they were diagnosed
- if they are still living
- what the behavior(s) are that put them at risk
- the general characteristics of who they are, and
- other information that helps you understand this epidemic.

Since 1993, the HIV Assessment Unit at the Washington State Department of Health has developed specific epidemiologic reports for each region and the state. The report for Region 4 (Seattle-King County) has been a joint effort by both DOH and Public Health – Seattle & King County (PHSKC).

For the 2002-2003 planning cycle, Regions 1, 2, 3, 5 and 6 received copies of regional epi profiles and a presentation from Maria Courogen, the Assessment Unit lead epidemiologist. The Prioritization Committee for the Region 4 (Seattle-King County) planning group received written materials and oral presentations from the PHSKC epi staff. (Attachment 3, 2002-2003 Plan, Attachment 6, 2003 UPDATE) (Region 4/King County reports are available at www.metrokc.gov/health/apu/epi)

WHAT'S NEW?

Nationally, the reported numbers of AIDS cases have declined due to the impact of highly active antiretroviral therapy (HAART). These medications and procedures have been prescribed since the mid-1990's. Since late 1998, their effects have slowed, resulting in a "stalling" of the trends at both the local and national levels. Reasons for this may include:

- reaching the limits of therapy in helping people live longer
- failing therapies due to treatment-resistant viral strains
- late HIV testing
- inadequate access to and adherence to treatment in some populations
- recent increases in HIV risk behaviors in some risk groups.

All of these factors have brought new challenges in prevention efforts.

As people have lived longer and looked healthier, they have been able to return to more normal lives. This created a double-edged sword. On one hand, it is great to feel better; on the other hand, the critical nature of the infection becomes less clear. Many young people have never seen a person with full-blown AIDS or attended a funeral of someone who has died of AIDS. This can give a false sense of freedom from the risks of HIV infection. Many communities choose to believe the new HIV treatments are a 'cure.' This reality makes knowledge of HIV status even more critical and generates great discussions about the importance of HIV reporting.

In 2001, there was increased focus on the global epidemic. Around the world, 40 million people are estimated to be living with HIV/AIDS. HIV/AIDS is the leading cause of death in Africa and the 4th leading cause of death globally. The disease is a public health crisis and development crisis for many countries and has been recognized as a security threat by the United Nations, the United States, and other governments around the world. In April 2001, the U.N. General Assembly, under the leadership of U.N. Secretary Kofi Annan, convened a special session to mobilize resources to fight AIDS, tuberculosis, and malaria.

Nationally, there are a number of challenges facing the country, one being to maintain attention on the U.S. epidemic while responding to the global crisis. New data from the Centers for Disease Control and Prevention (CDC) suggest that the era of sharp declines in AIDS deaths and new AIDS diagnoses has come to an end. An ambitious goal has been set to reduce the number of new HIV infections in the United States by half (40,000 to 20,000) by the year 2005. Other challenges include increasing the number of people with HIV/AIDS in care, addressing the disproportionate impact on racial and ethnic minorities, targeting at-risk populations and tailoring prevention interventions, integrating prevention and treatment, and reducing stigma.

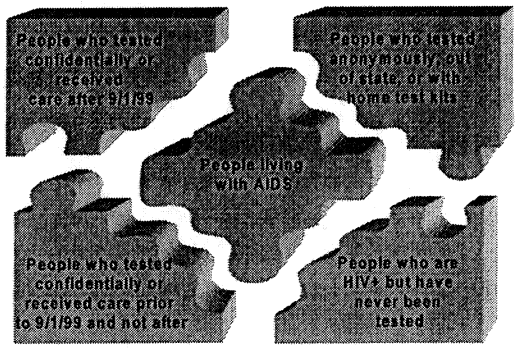
Locally, Washington State has the advantage of now being able to incorporate data from HIV reporting into the epidemiologic profile to further describe the epidemic. As is the case nationally, declines in AIDS incidence and AIDS deaths appear to have leveled off. While there have been shifts in the epidemic, there has also been continuing concern about the traditional risk populations. Although the proportion of Washington State AIDS cases attributable to men having sex with men has decreased over time, there is some evidence that this population may be experiencing a sexual safety relapse. Between 1997 and 2000, STD rates increased substantially among MSM in King County, and similar trends were seen in other cities in the U.S. and abroad. Increases in HIV seroprevalence have been seen in the King County STD clinic surveys, with a steady climb in seroprevalence from 4% in 1997 to 6% in 1998 to 11% in 1999. Other studies also indicate increases in unprotected anal sex and in numbers of sex partners in MSM that may be greater in younger men and men of color.

In terms of data collection, the biggest change in Washington was the initiation of HIV reporting in September of 1999. Preliminary analyses of these data, still not considered to be complete, confirm the shifts in the epidemic that were seen, in part, by the parallel AIDS data. As is the case with more recently diagnosed AIDS cases, HIV cases appear to include higher proportions of women, persons of color, and persons exposed through injection drug use or heterosexual contact. Additionally, implementing HIV reporting may have resulted in better reporting of AIDS cases due to increased lab reporting and general awareness by the medical community.

HIV Data

Preliminary HIV reporting data through 12/31/2000, describe asymptomatic (no symptoms) HIV cases reported to DOH as a result of the new reporting requirement, as well as symptomatic cases, which have been reported since 1987. All people living with HIV infection will fall into one of the 5 categories indicated in Figure 2.

Figure 2. People living with HIV infection



To understand reported HIV/AIDS data, is important to understand both their strengths and limitations. Data resulting from HIV reporting:

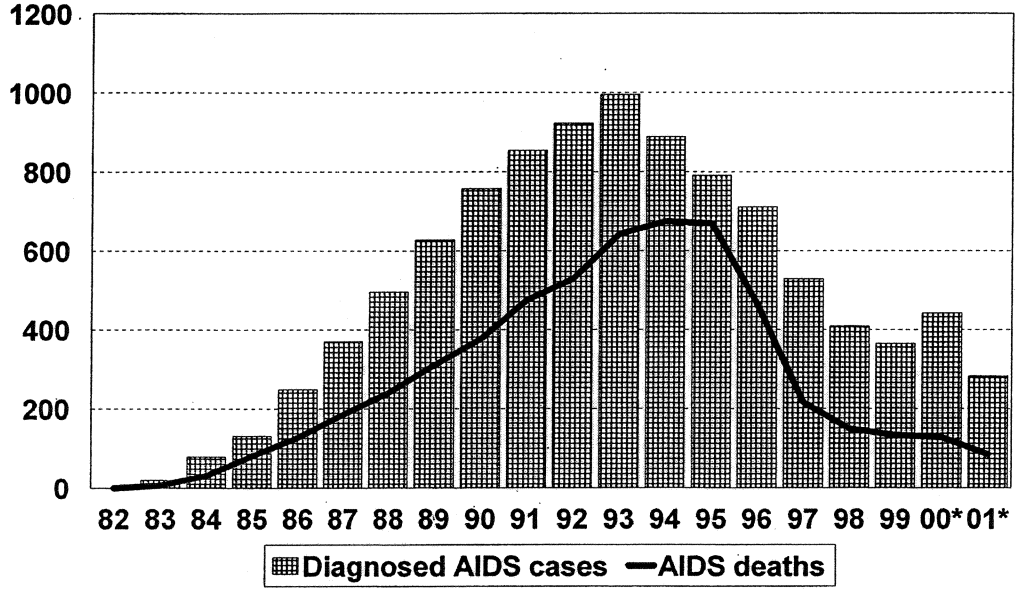
- Provide a *minimum estimate* of the number of HIV+ persons
- Describe those who are at an earlier point in their infection
- Do **not** effectively describe those who are newly infected (that is, do not give incidence information). The data system gathers the data at whatever point in the infection process that the person decides to be tested, rather than determining the actual point of infection. Therefore, HIV+ data could represent infections that are from weeks to years old.
- HIV data are not representative of all HIV-infected individuals. The universe of all HIV infected individuals is made up of the 5 categories in Figure 2.
- This information may not be available or complete for some groups. These data are considered to be >90% complete. There are people who know their HIV status because they tested anonymously, in another state, or with a home test kit and their information would not be included.
- The information for people who tested or received care prior to 9/1/99, but not after, will also not be included.
- Finally, there are those who have never been tested and are HIV infected, but do not know their status.

Preliminary data from each region and county indicate that HIV cases have been reported in all counties except Ferry, Garfield, Kittitas, Klickitat, Lincoln, Pacific, and Skamania. The year of diagnosis (earliest possible test result) ranges from 1984 to 2001. HIV cases include a higher proportion of cases with no identified risk. This is due to the earlier diagnosis in the course of the infection, the fact that people may not be aware of their risk factors and that people may not share information with a provider. Additionally, many cases of HIV are identified through laboratory reporting where associated risk factors are more difficult to track or determine.

Trends in AIDS cases and deaths

Starting in mid-1990, the number of reported AIDS cases and AIDS deaths decreased at an astounding rate. Figure 3 shows the declines and also shows the previously indicated 'stalling' of the trends starting in 1998

Figure 3 - UPDATE AIDS cases by year of diagnosis and AIDS deaths, Washington State 1982-2001 (Note: Cases reported as of 12/31/01; reporting for 2000 and 2001 is still not considered to be complete*)



With this decrease in the number of reported deaths of people with AIDS, the number of people living with AIDS (AIDS prevalence) has increased. This means that the proportion of people living with AIDS, after diagnosis, has steadily increased. Over the years this has contributed to a change in the trends of AIDS cases in each region and the state. Table 11 summarizes these changes.

UPDATED TABLE 11: AIDS case trends over three time periods, Washington State

	Year of diagnosis			
	1982-1989 n = 1974	1990-1997 n = 6649	1998-2001* n = 1498	Cumulative N = 9921
AIDSNET region				
Region 1	80 (4%)	366 (6%)	96 (6%)	542 (5%)
Region 2	49 (2%)	201 (3%)	69 (5%)	319 (3%)
Region 3	113 (6%)	533 (8%)	120 (8%)	766 (8%)
Region 4	1448 (73%)	4107 (64%)	847 (57%)	6402 (65%)
Region 5	173 (9%)	674 (10%)	228 (15%)	1075 (11%)
Region 6	111 (6%)	568 (9%)	138 (9%)	817 (8%)
Gender				
Male	1910 (97%)	5935 (92%)	1304 (87%)	9149 (92%)
Female	64 (3%)	514 (8%)	194 (13%)	772 (8%)
Mode of exposure				
MSM	1518 (77%)	4393 (68%)	837 (56%)	6748 (68%)
IDU	85 (4%)	613 (10%)	195 (13%)	893 (9%)
MSM/IDU	235 (12%)	624 (10%)	123 (8%)	982 (10%)
Heterosexual contact*	29 (1%)	382 (6%)	154 (10%)	565 (6%)
Receipt of blood products	77 (4%)	119 (2%)	13 (<1%)	209 (2%)
Mother at risk for HIV	8 (<1%)	18 (<1%)	2 (<1%)	28 (<1%)
No identified risk/other	22 (1%)	300 (5%)	174 (12%)	496 (5%)
Race/Ethnicity				
White	1730 (88%)	5124 (79%)	1009 (67%)	7863 (79%)
Black	130 (7%)	641 (10%)	250 (17%)	1021 (10%)
Hispanic	77 (4%)	434 (7%)	163 (11%)	674 (7%)
Asian/Pacific Islander	24 (1%)	120 (2%)	29 (2%)	173 (2%)
American Indian/Alaska Native	13 (1%)	126 (2%)	38 (3%)	177 (2%)
Unknown	0 (0%)	4 (<1%)	9 (<1%)	13 (<1%)
Age				
<13	12 (1%)	18 (<1%)	2 (<1%)	32 (<1%)
13-19	12 (1%)	20 (<1%)	6 (<1%)	38 (<1%)
20-29	394 (20%)	1162 (18%)	191 (13%)	1747 (18%)
30-39	938 (48%)	3037 (47%)	664(44%)	4639 (47%)
40-49	422 (21%)	1633 (25%)	441 (29%)	2496 (15%)
50+	196 (10%)	579 (9%)	194 (13%)	969 (10%)

For more detail, please refer to Regional Epi Profiles in Attachment 3 of 2002-2003 Plan, Attachment 6, 2003 UPDATE

HIV/AIDS in behaviorally defined populations

Tables 12, 13 and 14 (next 3 pages) summarize the most recent epidemiologic data for people living with HIV, AIDS and cumulative cases. These data establish a picture of the epidemic changing slightly (Table 15). While MSM are still the most common risk factor for contracting HIV, the relative proportion of MSM has decreased. The number of cases attributed to both MSM and IDU behavior (MSM/IDU) has remained steady throughout the reported data. As a result of these decreases, balancing increases have been seen in other populations. IDU cases have increased in 5 regions and heterosexual cases have increased in all six regions. The number

2003 UPDATED - Table 12. HIV cases reported as of 12/31/01

	WA State N = 2,952	Region 1 N = 123	Region 2 N = 85	Region 3 N = 227	Region 4 N = 1,992	Region 5 N = 324	Region 6 N = 201
Year of diagnosis							
1982 – 1989	428 (14%)	20 (16%)	11 (13%)	32 (14%)	302 (15%)	39 (12%)	24 (12%)
1990-1997	1,393 (47%)	54 (44%)	38 (45%)	123 (54%)	908 (46%)	167 (51%)	103 (51%)
1998	202 (7%)	9 (7%)	7 (8%)	9 (4%)	160 (8%)	8 (2%)	9 (4%)
1999	293 (10%)	8 (7%)	13 (15%)	22 (10%)	187 (9%)	36 (11%)	27 (13%)
2000	386 (13%)	18 (15%)	9 (11%)	23 (10%)	273 (14%)	46 (14%)	17 (8%)
2001	250 (8%)	14 (11%)	7 (8%)	18 (8%)	162 (8%)	28 (9%)	21 (10%)
Gender							
Male	2,500 (85%)	101 (82%)	61 (72%)	183 (81%)	1,765 (89%)	232 (72%)	158 (79%)
Female	452 (15%)	22 (18%)	24 (28%)	44 (19%)	227 (11%)	92 (28%)	43 (21%)
Race/Ethnicity							
White	2,186 (74%)	98 (80%)	50 (59%)	188 (83%)	1,465 (74%)	217 (67%)	168 (84%)
Black	413 (14%)	11 (9%)	6 (7%)	16 (7%)	305 (15%)	62 (19%)	13 (6%)
Hispanic	215 (7%)	7 (6%)	27 (32%)	12 (5%)	137 (7%)	27 (8%)	5 (2%)
Asian/Pac. Island.	65 (2%)	1 (1%)	1 (1%)	6 (3%)	44 (2%)	9 (3%)	4 (2%)
AmerInd/AlaskaNat	48 (2%)	3 (2%)	0 (0%)	4 (2%)	31 (2%)	7 (2%)	3 (1%)
Unknown	25 (1%)	3 (2%)	1 (1%)	1 (<1%)	10 (1%)	2 (1%)	8 (4%)
Mode of exposure							
MSM	1,795 (61%)	51 (41%)	36 (42%)	115 (51%)	1,378 (69%)	137 (42%)	78 (39%)
IDU	312 (11%)	23 (19%)	12 (14%)	27 (12%)	134 (7%)	77(24%)	39 (19%)
MSM/IDU	261 (9%)	12 (10%)	10 (12%)	22 (10%)	176 (9%)	27 (8%)	14 (7%)
Heterosexual	257 (9%)	15 (12%)	14 (16%)	31 (14%)	117 (6%)	50 (15%)	30 (15%)
Blood Products	26 (1%)	0 (0%)	3 (4%)	2 (1%)	16 (1%)	2 (1%)	3 (2%)
Other/Unknown	301 (10%)	22 (17%)	10 (11%)	30 (13%)	171 (9%)	31 (10%)	37 (18%)
Age at HIV diagnosis							
<13	33 (1%)	3 (2%)	2 (2%)	4 (2%)	17 (1%)	4 (1%)	3 (1%)
13-19	86 (3%)	2 (2%)	7 (8%)	10 (4%)	50 (3%)	10 (3%)	7 (3%)
20-29	1,019 (35%)	47 (38%)	34 (40%)	74 (33%)	674 (34%)	123 (38%)	67 (33%)
30-39	1,197 (41%)	41 (33%)	30 (35%)	88 (39%)	852 (43%)	119 (37%)	67 (33%)
40-49	481 (16%)	25 (20%)	6 (7%)	36 (16%)	311 (16%)	58 (18%)	45 (22%)
50+	136 (5%)	5 (4%)	6 (7%)	15 (7%)	88 (4%)	14 (4%)	12 (6%)

(Cases reported as of 12/31/01; case reporting for 2000 and 2001 is still not considered to be complete)

2003 UPDATED - Table 13. People living with AIDS as of 12/31/01

	WA State N = 4,395	Region 1 N = 249	Region 2 N = 153	Region 3 N = 351	Region 4 N = 2,731	Region 5 N = 504	Region 6 N = 407
Year of diagnosis							
1982 – 1989	130 (3%)	7 (3%)	4 (3%)	2 (1%)	97 (4%)	12 (2%)	8 (2%)
1990-1997	2,923 (67%)	160 (64%)	88 (58%)	241 (69%)	1,868 (68%)	291 (58%)	275 (68%)
1998	356 (8%)	13 (5%)	16 (10%)	37 (11%)	224 (8%)	40 (8%)	26 (6%)
1999	321 (7%)	25 (10%)	12 (8%)	28 (8%)	174 (6%)	51 (10%)	31 (8%)
2000	397 (9%)	31 (12%)	17 (11%)	24 (7%)	230 (8%)	64 (13%)	31 (8%)
2001	268 (6%)	13 (5%)	16 (10%)	19 (5%)	138 (5%)	46 (9%)	36 (9%)
Gender							
Male	3,928 (89%)	232 (93%)	128 (84%)	297 (85%)	2,526 (92%)	392 (78%)	353 (87%)
Female	467 (11%)	17 (7%)	25 (16%)	54 (15%)	205 (8%)	112 (22%)	54 (13%)
Race/Ethnicity							
White	3,255 (74%)	199 (80%)	86 (56%)	288 (82%)	2,006 (73%)	340 (67%)	336 (83%)
Black	557 (13%)	12 (5%)	6 (4%)	21 (6%)	389 (14%)	96 (19%)	33 (8%)
Hispanic	398 (9%)	18 (7%)	58 (38%)	21 (6%)	234 (9%)	41 (8%)	26 (6%)
Asian/Pac. Island.	80 (2%)	3 (1%)	1 (1%)	8 (2%)	50 (2%)	13 (3%)	5 (1%)
AmerInd/AlaskaNat	96 (2%)	9 (4%)	2 (1%)	13 (4%)	52 (2%)	14 (3%)	6 (1%)
Unknown	9 (<1%)	8 (3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (<1%)
Mode of exposure							
MSM	2,764 (63%)	113 (53%)	77 (50%)	193 (55%)	1,933 (71%)	220 (44%)	208 (51%)
IDU	477 (11%)	46 (18%)	16 (10%)	30 (9%)	195 (7%)	104 (21%)	86 (21%)
MSM/IDU	395 (9%)	23 (9%)	13 (9%)	29 (9%)	253 (9%)	46 (9%)	31 (8%)
Heterosexual	361 (8%)	13 (5%)	22 (14%)	49 (14%)	164 (6%)	75 (15%)	38 (9%)
Blood Products	63 (1%)	5 (2%)	1 (1%)	11 (3%)	23 (1%)	13 (3%)	10 (2%)
Other/Unknown	335 (8%)	29 (12%)	24 (16%)	39 (11%)	163 (6%)	46 (9%)	34 (8%)
Age at AIDS diagnosis							
<13	13 (<1%)	1 (<1%)	1 (1%)	0 (0%)	6 (<1%)	4 (1%)	1 (<1%)
13-19	19 (<1%)	3 (1%)	1 (1%)	2 (1%)	4 (<1%)	5 (1%)	4 (1%)
20-29	767 (17%)	40 (16%)	51 (33%)	62 (18%)	465 (17%)	85 (17%)	64 (16%)
30-39	2,106 (48%)	114 (46%)	56 (37%)	156 (44%)	1,357 (50%)	231 (46%)	192 (47%)
40-49	1,117 (25%)	63 (25%)	28 (18%)	102 (29%)	694 (25%)	123 (24%)	107 (26%)
50+	373 (8%)	28 (11%)	16 (10%)	29 (8%)	205 (8%)	56 (11%)	39 (10%)

(Cases reported as of 12/31/01; case reporting for 2000 and 2001 is still not considered to be complete)

2003 UPDATED - Table 14. Demographic characteristics and risk profiles of people living with HIV/AIDS in Washington State by AIDSNet region. (Cases reported as of 12/31/01; reporting for 2000 and 2001 is still not considered to be complete).

	Region 1 N = 366	Region 2 N = 233	Region 3 N = 571	Region 4 N = 4,656	Region 5 N = 811	Region 6 N = 603	Total N = 7,240
Gender							
Male	327 (89%)	185 (79%)	475 (83%)	4231 (91%)	615 (76%)	508 (84%)	6341 (88%)
Female	39 (11%)	48 (21%)	96 (17%)	425 (9%)	196 (24%)	95 (16%)	899 (11%)
Race/Ethnicity							
White	291 (80%)	132 (57%)	471 (82%)	3418 (73%)	547 (67%)	499 (83%)	5358 (74%)
Black	23 (6%)	12 (5%)	36 (6%)	682 (15%)	155 (19%)	46 (8%)	954 (13%)
Hispanic	25 (7%)	84 (36%)	32 (6%)	371 (8%)	65 (8%)	31 (5%)	608 (8%)
Asian/Pacific Islander	4 (1%)	2 (1%)	14 (2%)	94 (2%)	22 (3%)	9 (1%)	145 (2%)
American Indian/AlaskNat	12 (3%)	2 (1%)	17 (3%)	82 (2%)	20 (2%)	9 (1%)	142 (2%)
Unknown	11 (3%)	1 (<1%)	1 (<1%)	9 (<1%)	2 (<1%)	9 (1%)	33 (<1%)
Mode of HIV exposure							
MSM	179 (49%)	111 (48%)	305 (53%)	3269 (70%)	351 (43%)	284 (47%)	4499 (62%)
IDU	69 (19%)	27 (12%)	55 (10%)	321 (7%)	175 (22%)	124 (21%)	771 (11%)
MSM/IDU	34 (9%)	22 (9%)	51 (9%)	417 (9%)	72 (9%)	45 (7%)	641 (9%)
Heterosexual	28 (8%)	36 (15%)	79 (14%)	279 (6%)	123 (15%)	67 (11%)	612 (8%)
Receipt of blood products	5 (1%)	3 (1%)	11 (2%)	39 (<1%)	15 (2%)	13 (2%)	86 (1%)
Mother with HIV risk	4 (1%)	3 (1%)	3 (<1%)	21 (<1%)	7 (<1%)	4 (<1%)	42 (<1%)
No identified risk/other	47 (13%)	31 (13%)	67 (12%)	309 (7%)	68 (8%)	66 (11%)	588 (8%)

of cases in women (proportionally) has increased as cases in men have decreased. For HIV cases, diagnosis has been 10 years earlier than AIDS diagnoses, as would be anticipated by the normal course of the disease. In terms of racial and ethnic groups, cases in whites have decreased, while cases in communities of color have increased. Table 12 is a summary of the changes in the various demographics of the epidemic between the time periods 1985-89 and 1995-1999. The following table (Table15) is a comparison of the cumulative AIDS data and the people living with AIDS as of December 31, 2001. The data on people living with AIDS not only reflects the people who are still alive, but also people who have probably been infected more recently in the epidemic. Clearly indicated are increases in the number of women. Increases in the African American, Hispanic, IDU, and heterosexual categories are also indicated. There was no change in the age of diagnosis.

TABLE 15 Comparison of cumulative AIDS cases and number of people living with AIDS in Washington State as of December 31, 2000

	Cumulative AIDS cases N = 9,421	% total of cumulative AIDS cases	People living with AIDS N = 4,060	% total of people living with AIDS
Gender				
Male	8705	92%	3633	89%
Female	716	8%	427	11%
Race/Ethnicity				
White	7527	80%	3044	75%
Black	925	10%	483	12%
Hispanic	628	7%	362	9%
Asian/Pacific Is	162	2%	74	2%
Amerind/AlaskNat	167	2%	89	2%
Unknown	12	<1%	8	<1%
Mode of exposure				
MSM	6442	68%	2560	63%
IDU	846	9%	450	11%
MSM/IDU	941	10%	374	9%
Heterosexuals	496	5%	303	7%
Blood products	205	2%	62	2%
Other/unknown	491	5%	311	8%
Age of AIDS diagnosis				
<13	33	<1%	14	<1%
13-19	37	<1%	18	<1%
20-29	1704	18%	740	18%
30-39	4403	47%	1933	48%
40-49	2339	25%	1021	25%
50-59	685	7%	269	7%
60+	220	2%	65	2%

A comparison of people living with AIDS by gender and mode of transmission (Table 16) also helps to understand the differences between the genders in this epidemic. Men, of course, are distributed between all of the modes of transmission with MSM still in the majority. Women face their highest risk from partners who are HIV+ due, primarily, to transmission from their own MSM or IDU behaviors. The second significant mode of transmission for women is their own IDU behaviors. Knowing, however, that to be categorized as a heterosexual transmission,

the risk of the partner must be known, the high number of women who report 'other or no known risks' may eventually be identified as heterosexual transmission (if their partner can be identified and confirmed as HIV+). These data link HIV in women with the risk behaviors of their male partners.

UPDATED - Table 16. Adults and adolescents living with HIV/AIDS, by HIV exposure category and sex, Washington State. (Cases reported as 12/31/01; case reporting for 2000 and 2001 is still not considered to be complete.)

HIV Exposure Category	Males	Females	Washington Total
Men who have sex with men (MSM)	4499 (71%)		4499 (63%)
Female and heterosexual male injection drug users	519 (8%)	252 (29%)	771 (11%)
MSM who use injection drugs	641 (10%)		641 (9%)
Heterosexual contacts *	194 (3%)	418 (48%)	612 (9%)
Receipt of blood products	64 (1%)	22 (3%)	86 (1%)
Other/unknown	405 (6%)	181 (21%)	586 (8%)
TOTAL	6322	873	7195

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

Another area of concern nationally and locally is the increasing cases of HIV and AIDS among people of color, especially among African American and Hispanic communities (Table 17A and 17B). The following data on mode of transmission and race/ethnicity for people living with HIV, was considered (specifically for each region). The total state data reflects the trends in all regions. Regional data can be reviewed in Attachment 3 of 2002-2003 Plan, Attachment 6, 2003 UPDATE

UPDATED TABLE 17A: Adults and adolescent MALES living with HIV/AIDS, by exposure category and race/ethnicity, Washington State. (Cases reported as December 31, 2001; case reporting for 2000 and 2001 is still not considered to be complete).**

HIV Exposure Category	White	Black	Hispanics	Asian/PI	Amer.Ind. AK Nat.
Men who have sex with men	3684 (76%)	336 (49%)	328 (62%)	87 (76%)	49 (47%)
Heterosexual male injection drug users	328 (7%)	104 (15%)	62 (12%)	6 (5%)	18 (17%)
MSM who use injection drugs	512 (11%)	54 (8%)	39 (7%)	4 (3%)	30 (29%)
Heterosexual contacts*	79 (2%)	79 (12%)	26 (5%)	5 (4%)	4 (4%)
Sex with IDU	*29*	*8*	*10*	*1*	*1*
Sex with blood recipient	*2*	*0*	*0*	*0*	*0*
Sex with HIV+/AIDS	*48*	*71*	*16*	*4*	*3*
Receipt of blood products	54 (1%)	1 (<1%)	7 (1%)	1 (<1%)	0 (0%)
Other/unknown	212 (4%)	108 (16%)	63 (12%)	12 (10%)	3 (3%)
TOTAL	**4869**	**682**	**525**	**115**	**104**

Table 17B. Adults and adolescent FEMALES living with HIV/AIDS, by exposure category and race/ethnicity, Washington State. (See above note)**

HIV Exposure Category	White	Black	Hispanics	Asian/Pacific Islanders	Amer.Ind. Alaska Nat.
Men who have sex with men					
Female and heterosexual male injection drug users	156 (33%)	61 (24%)	11 (14%)	1 (4%)	23 (62%)
MSM who use injection drugs					
Heterosexual contacts*	227 (48%)	116 (46%)	51 (66%)	13 (48%)	8 (22%)
Sex with bisexual male	*26*	*5*	*3*	*0*	*1*
Sex with IDU	*76*	*29*	*11*	*0*	*3*
Sex with blood recipient	*9*	*2*	*0*	*1*	*0*
Sex with HIV+/AIDS	*116*	*80*	*37*	*12*	*4*
Receipt of blood products	9 (2%)	9(4%)	1 (1%)	3 (11%)	0 (0%)
Other/unknown	81 (17%)	68 (27%)	14 (18%)	10 (37%)	6 (16%)
TOTAL	**473**	**254**	**77**	**27**	**37**

*Heterosexual contacts of a person known to have HIV or be at risk for HIV.

All regions have identified youth (<24) as a priority population. Table 18 describes the number and percent of AIDS cases in people under the age of 24 by mode of transmission.

TABLE 18
Mode of HIV exposure by regions among adolescent and young adults (13-24 years) by region 1983-2000.

MODE	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	TOTAL (mode)
MSM	11(39%)	10(34%)	9 (36%)	94(58%)	28(41%)	20(51%)	172(49%)
IDU	3 (11%)	3 (10%)	1 (4%)	13 (8%)	10(14%)	4(10%)	34(10%)
MSM/IDU	4 (14%)	3 (10%)	4 (16%)	26(16%)	8(12%)	1 (3%)	46(13%)
Heterosexual	4 (14%)	6 (21%)	5 (20%)	11 (7%)	7(10%)	6(15%)	39(11%)
Blood prdts	5 (18%)	3 (10%)	3 (12%	8 (5%)	8(12%)	4(10%)	31 (9%)
Other/unk	1 (4%)	4 (14%)	3 (12%)	10 (6%)	8(12%)	4(11%)	30 (9%)
TOTAL (Region)	28 (8%)	29 (8%)	25 (7%)	162(46%)	69(20%)	39(11%)	352

Percentages in regional data reflect % in region (column) or total. Percentages in last row (TOTAL – region) reflect % of adolescent cases in region.

All planning groups have received epi profile information and data on surrogate measures that they might consider in their decision making process. These measures may include STD, TB, Hepatitis B and C, and teen pregnancy data.

GAP ANALYSIS

Draft guidance for gap analysis was developed in 2000-2001. This guidance was presented at the Community Planning Summit in Houston, TX in March of 2001. Several regional planning groups have begun completing the gap analysis for their region. Region 2 has completed the section on MSM and will be seeking information to clarify unanswered questions. Region 3 has begun the process of gathering the information needed to complete the analysis. A copy of the guidance is included in Attachment 4 of the 2002-2003 HIV Prevention Plan, Attachment 6, 2003 UPDATE.

UPDATE - NEEDS ASSESSMENTS

All planning groups have discussed the needs assessment process in their regions. Due to issues around human subjects review, limitations for the gathering of certain behaviorally specific information led most planning groups to feel thwarted in attempting any population specific assessments. As a response to this issue, the DOH Assessment Unit is developing the protocols for key informant interviews, focus groups and surveys that will meet human subject review criteria. The new *Prioritized Population Needs Assessment Guidance* and *Prioritized Population Needs Assessment Focus Group Protocol* was approved by the SPG (Attachment 3A and 3B of 2003 UPDATE). (The *Prioritized Population Needs Assessment Key Informant Interview Protocol* will be issued in October 2002.

On a statewide basis, DOH funded two needs assessments in 2001-2002: American Indian tribes and seasonal/migrant farm worker intervention needs. The American Indian Assessment yielded little, if any, useable information. The final conclusion was that the increased availability of condoms is the best intervention for tribal settings in Washington. This issue will be studied further in the future. The Seasonal and Migrant Farm Worker Needs Assessment will be completed by December 2002. Results of this survey will be available to the state and regional planning groups in January 2003.

As part of the extensive prioritization process in Seattle-King County (Region 4), several needs assessment documents were reviewed. These documents included the Young Men's Study, A Public Health Perspective, Prevention Prioritization for 2002-2003, the findings/report of the MSM Summit, and other nationally published materials. All of these materials were also shared with the other planning groups (see Attachment 5 of the 2002-2003 Plan Attachment 6, 2003 UPDATE, for materials and/or references).

The State Planning Group (SPG) received a report on the KABB (Knowledge, Attitudes, Beliefs and Behaviors) Survey and the relevant questions in the BRFSS (Behavioral Risk Factor Surveillance Survey) data (see Attachment 5 of the 2002-2003 Plan, Attachment 6, 2003 UPDATE for summary information).

The State Planning Group (SPG), along with input from the regional planning groups, have prioritized a statewide needs assessment of young gay men of color to be conducted in 2002. Other indicated assessments will be completed on a statewide or local basis as funding becomes available.

COMMUNITY RESOURCE INVENTORY

The SHARE (Statewide HIV Activities, Reporting and Evaluation) System is now fully operational and in its second year of data collection. All federally, state or other funded interventions, except counseling and testing and partner notification, are tracked through SHARE. A community resource inventory that lists region, agency, interventions, funding and other pertinent data can be generated as needed. This listing would provide a majority of the primary prevention activities and providers in the state. If a region chooses to list additional providers of HIV services, that inventory will be included in their local plan.

In 2002, the following organizations provided HIV prevention services in Washington: (Region in parenthesis)

Adams County Health District (1)
Asotin County Health District (1)
Baker Street Ministries (1, 5)
Benton-Franklin Health Dist (2)
Blue Mountain Heart to Heart (1)
Brother to Brother (4,5)
Chelan-Douglas Health Dist (2)
Clallam County Dept of Health & Human Services (6)
Consejo (4)
Cowlitz County Health Dept (6)
Department of Health (WA)
Evergreen AIDS Foundation (3)
Garfield County Health Dist (1)
Gay City (4)
Good Samaritan Hospital, Pierce County (5)
Grant County Health Dist (2)
Grays Harbor County Public Health and Social Services Department (6)
Home Alive (4)
International Community Health Services(4)
Island County Health Dept (3)
Jefferson County Health & Human Svcs (6)
KDNA Radio & TV (2)
Kitsap County Health Dist (5)
Kittitas County Health Dept (2)
Klickitat County Health Dept (2)
Lewis County Public Health (6)
Lifelong AIDS Alliance (4) (formerly Northwest AIDS Foundation)
Lincoln County Health Dept (1)
Mason County Dept. of Health Svcs (6)
NE Tri-Counties Health Dist (1)
Okanogan County Health Dist (1)
OUTKitsap (5)
Pacific County Health & Human Svcs (6)
Pierce County AIDS Foundation (5)
Planned Parenthood of Western WA
POCAAN – Seattle (4)
POCAAN – Tacoma (5)
POCAAN – Yakima (5)
Point Defiance AIDS Project (5)
Public Health – Seattle & King County (4)
Region 1-Agency
Region 3-Agency
San Juan Co. Health & Community Services (3)
Sisters of Perpetual Indulgence (4)
Skagit County Dept of Health (3)
Snohomish Health Dist (3)
Spokane AIDS Network (1)
Spokane Regional Health Dist (1)
Stonewall Recovery Svds – Project NEON (4)
Stonewall Youth (6)
Street Outreach Services (4)
SW WA Health Dist (6)
Tacoma Urban League (5)
Tacoma-Pierce County Health Dept (5)
Thurston County Health Dept (6)
University of Washington - HAPDEU
University of Washington - Project SHAPE
Walla Walla County-City Health Dept (1)
Whatcom County Health & Human Services Dept (3)
Whitman County Health Dept (1)
Yakima Health Dist (2)
YouthCare (4)

2003 UPDATE
SUMMARY OF REGIONAL PRIORITIZATION

Each of the regions is at a different point in their prioritization process. This variability is due to:

- the different planning calendars
- decisions on what part of the process to focus on
- the size of the regional epidemic, and
- regional capacity to plan and implement interventions.

REGION 1

Region 1 is in the third year of their plan and focused on effective interventions and prioritization of populations. As a result of these efforts, Region 1 is utilizing behavioral categories to identify the prioritized populations. The following is a summary of their Priority Populations:

Region 1 2003 Priority Populations

HIV+ and partners
All HIV+ individuals and their partners **Multiple partners, unprotected intercourse and sharing needles.**
MSM
Sex partners, including multiple, unprotected sex and survival sex
MSM – general
MSM/IDU
Youth (14-24)
People of Color
Non-gay Identified
Use Alcohol and Drugs
People with STD
IDU
Multiple partners, unprotected intercourse and sharing needles.
General
Needle sharing
Youth (14-24)
People of Color – Hispanic/Latino
Incarcerated
In Drug Treatment
With an STD

Heterosexuals at risk were considered in the 'partner' populations of the risk categories, not as a separate category.

The rationale for ranking HIV+ and their partners as the number 1 behavioral risk category was based on the literature supporting early intervention and prevention case management (PCM) and their direct effect in reducing risk behaviors. Data concerning increased risk of transmission with multiple sex partners, especially in public sex environments with multiple anonymous partners were reviewed. Increased cases of syphilis and gonorrhea in gay men in the Seattle area were of particular concern. This concerns stems from reports by the gay community and RPG members of frequent travel to the Seattle area to 'party.' STD rates in Region 1 will continue to be monitored. AIDS cases in people of color in Region 1 exceed or equal the percent of that race/ethnicity in the general population for the region. African Americans are 1% of the population and 4% of the cumulative AIDS cases; Hispanics are 6% of the population and 5% of the AIDS cases, and American Indians are 2% of the general population and 3% of the AIDS cases. While the actual number of cases are small, the increases are troubling. (see Attachment 3, 2002-2003 Plan, Region 1, Attachment 6, 2003 UPDATE, for further details and discussion of epidemiologic findings)

The Region 1 planning group did not separately prioritize the effective interventions, but adopted the SPG recommendations (Table 9). The selection of programs to meet these priorities was based on what was already being done, the capacity of the resources in the area and the plans that outcome monitoring will provide more concrete information about program success. Additionally, several of the programs will be evaluated over the 2002 calendar year. For HIV+ and their partners, PCM was identified as an effective intervention and is available in Spokane. The Spokane program involves a CDC directly funded program called Milestones at the Spokane AIDS Network. Spokane AIDS Network is also directly funded, by the CDC, to provide a group-level intervention for MSMs called Positive Power.

Region 1 and Region 2 have entered into a joint project to adapt the L.A. Oasis Project (Dr. Wilbert Jordan) to a rural setting as an individual intervention, *Know Your Status*, Person @Risk. Dr. Jordan has consented to provide the technical assistance to this project and has secured external funding for his participation and the evaluation of this project.

A variety of interventions have been identified for people of color, specifically a reservation based peer education project called *ROPED* and migrant farm worker outreach by bilingual workers. Most of the local health departments provide jail based education and counseling and testing programs. All the local health departments provide access to high-risk counseling and testing, both confidentially and anonymously.

REGION 2

Region 2 has a 5-year plan (2002-2007) in which the planning process will focus each year on a behavioral risk category, starting with MSM. In 2003, the Region 2 planning group will complete the gap analysis, assessment and prioritization of interventions for IDU. Additionally, the planning group received technical assistance, in 2002 (open to all workers in the state), from the Farmworkers Justice Fund on interventions to the seasonal farm worker community. Curricula for group level interventions for this population was developed and successfully implemented in 2002. Region 2 will continue to participate, with Region 1, in the *Know Your Status* project.

Hispanics are 25% of the total population in Region 2 and account for 28% of the cumulative AIDS cases and 34% of persons living with AIDS. All counties in Region 2 have targeted bilingual programs for Hispanics, including utilization of media through the local Spanish language radio and television station.

Region 2 2003 Priority Populations

MSM
HIV+/Partners
Youth (<24)
Non-identifying
MSM/IDU
Engaging in unprotected anal intercourse or multiple partners
IDU
IDU – general
Drug treatment
Multiple sex partners
Incarcerated
Latino
Heterosexuals
HIV+/partners
People of Color – Hispanic/Latino
With STD
General Population

REGION 3

Region 3 has dedicated this year's planning process to the prioritization process. As a result, they determined target populations based on behavioral risk categories, as follows:

Region 3 2003 Priority Populations

MSM
HIV+/partners
Unprotected anal intercourse or multiple sex partners, including survival sex
With STD
MSM/IDU
IDU
HIV+/partners
Multiple sex partners
Incarcerated
With STD

Region 3 Priority Populations cont.

Heterosexual
HIV+/partners
With STD
Women/partners of at risk males

REGION 4 – from 2002-2003 Plan

Region 4 developed a new plan for 2002-2003. The planning committee formed a Prioritization Subcommittee in April 2001. This committee consisted of 24 members representing the infected/affected communities, community-based organizations serving people at risk for or with HIV and public health. In over 48 hours of meetings, with 2 facilitators and numerous expert presenters, the subcommittee received information and data; met in small groups to prioritize subpopulations within the four priority populations (MSM, IDU, Heterosexual and Transgender); established the target funding levels for each of the four risk populations and prioritized the effective interventions (strategies). Much of the information and data presented at these meetings were shared with other regions, especially the Young Men's Study, the Public Health Perspectives, and the MSM STD Summit (see Attachment 6 of the 2002-2003 Plan for copies or sources of this information) Additionally, extensive review of the effective intervention literature became the basis for the state planning group effective interventions matrix and discussion at the regional level of this information (see Attachment 2, 2002-2003 Plan, Attachment 6, 2003 UPDATE).

Region 4 Priority Populations

MSM
HIV+
Men of Color
Injection Drug Users
HIV-negative men and men who do not know their serostatus
Youth
All MSM subpopulations
Heterosexuals
Female partners of high-risk males
Men and Women with STD's
IDU
Homeless and/or chronically involved in the legal system
Women engaged in survival sex
Young (<25 years old) and/or new injectors (<3 years)
HIV+ and/or HCV+
Transgender
Male-to-female persons who engage in anal sex, oral sex, and/or are HIV positive

REGION 5

Region 5 has two separate community planning groups (CPG), Kitsap County and Pierce County. The Kitsap planning group prioritized their populations based on the epi profile. Effective interventions were prioritized based on effective intervention literature, SPG recommendations, and the community resource inventory. There were no changes for 2003.

Region 5 – Kitsap Priority Populations

MSM
Gay identifying
HIV+
Young (16-24)
Non-gay identifying
MSM/IDU
Methamphetamine users
Heroin users
IDU
Heroin user
Methamphetamine user
Heterosexual
Partners of HIV +
Survival sex

The UPDATED prioritization process for the Pierce County CPG was very thorough and resulted in a behaviorally based list of prioritized populations

Region 5 – Pierce Priority Populations

HIV+/and their partners
MSM
African American
MSM/IDU
Youth (14-24)
IDU
African American
HIV+/partners
Homeless
Incarcerated
Latino/a
Youth
General
Heterosexual
HIV+/partners
African American Women
Latino/a

REGION 6

Region 6 planning group determined their behavioral risk category priorities as IDU, MSM and Heterosexual. Discussion in the planning group revolved around the epi profile that indicated that MSM is the highest risk behavior for transmission. Utilizing trend data, community resource inventory and literature supporting the increase in IDU populations convinced the planning group to rank IDU first in the priority order.

Region 6 Priority Populations

IDU
HIV+
Injectors
MSM
POC
Youth
MSM
HIV+
Youth
HIV+ partner
IDU
Male POC
Multiple sex partners
Heterosexual
HIV+
HIV+ partners
Multiple sex partners
POC
Survival sex
Female partners: IDU
MSM

(see Table 19 for details of priorities and interventions for all regions)

WHERE

WE

WILL

GO

FROM

HERE

2003 UPDATE - WHERE WE WILL GO FROM HERE

The purpose of planning is to set priorities for populations to be served and methods to be used to decrease risk behaviors. Successful interventions should result in decreased transmission of HIV in the target population. This definitely has been shown to be true. The very early prevention efforts in this country were focused on gay men and injection (intravenous) drug users. In the gay community, campaigns and programs targeting gay men, safer sex, condom acceptance and community empowerment resulting in decreasing numbers of new infections. Gay men were often the driving force of and for services to their own community. In the drug using community in Washington proposed interventions came from both the community and public health. The founding of the Point Defiance AIDS Project in Tacoma in 1987 was a landmark event and the beginning of legal needle exchanges in the United States. This early innovative program has likely contributed to the stabilization of HIV prevalence rates in IDU's at less than 4% through the entire epidemic. The relative number of injectors who are alive and infected has increased, but the rate of increase of actual new cases of HIV have remained stable. This has not been true in communities where needle exchanges are not available.

After 20 years of this epidemic devastating these communities and great advances in medical treatment, even the communities have lost sight of the day to day prevention activities and we are at the edge of losing some of the previous successes. In many communities of color the issues of HIV are critical. The planning groups have taken much of this information, as well as that from epidemiology, behavioral and social sciences and health planning, and tried to set priorities for scientifically based, effective interventions to be funded in their regions.

Throughout the year the planning groups received copies of articles, cross-referenced bibliographies, reports and advise from experts on populations, interventions and epidemic. From this information and the expertise and knowledge on the planning group, recommendations are made on what will fit best with the resources available, the target subpopulations and the 'state-of-the-art.' Each of the planning groups is at a different stage in this process. A copy of the PROGRESS REPORTS from each regional plan can be found in ATTACHMENT 5, 2003 UPDATE.

Table 19 (UPDATED) provides a summary of the Prioritized Populations, the Prioritized Effective Interventions identified for that population, the Actual Plan that has been entered into the SHARE system and the sources of funding for the intervention. CDC means that funding is part of the Washington State CDC Cooperative Agreement. State and Other funding reflects state Omnibus funding, local funding or donations, grants or funding from private or other public sources.

TABLE 19

PRIORITIZED POPULATIONS AND INTERVENTIONS, ACTUAL INTERVENTIONS, AND FUNDING BY REGION.

This table summarizes the information in the regional prevention and intervention plans. While every effort has been made to include both CDC funded and state/other funded interventions, the regional plans were only required to include the CDC funded programs. This information provides an overview of the statewide efforts. (Definitions of phrases, abbreviations and acronyms in table can be found on the previous page)

2003 Updated PRIORITIZED POPULATIONS, INTERVENTIONS AND FUNDING BY REGION. The following table reflects the information for 2003. Changes are noted in bold type. Because prioritization is an on-going process, changes in one area may not be reflected in another until the following year, i.e. a change in the prioritized populations may take at least one year to be reflected in interventions.

*HIV+	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
2003 Region 1	**HIV+ and/or their partners who:** **1. have multiple sex partners** **2. engage in unprotected sex** **3. engage in needle sharing**	**PCM, GLI, ILI, CLI (POC); CTR/PCRS; Person @Risk model**	**PCM – Milestones – SAN** **GLI – Positive Power - SAN** **CTR/PCRS – Spokane HD, Lincoln Co, Blue Mountain Heart to Heart** **CTR – Know Your Status – Spokane HD**	 X X	 X X
Region 5 – Pierce	**HIV+ and their partners, including latino/a**	**PCM, NEX, ILI, CTR/PCRS; Person @Risk model**	CTR/PCRS **PCM** **ILI – Early Intervention – TPCHD** **NEX – PDAP/TPCHD**	X X 	X X X X

*HIV+ was identified as a separate risk category by Regions 1 and 5-Pierce. HIV+ was identified as a population in all other regions.

MSM	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
2003 Region 1*	MSM – **Sex Partners (including multiple, unprotected and survival sex)**	CLI, GLI, Outreach, ILI; Social Marketing, Media; CTR/PCRS	CLI – F2F – SAN CTR/PCRS – all jurisdictions **CTR – Blue Mt. Heart to Heart** **HCPI – Prevention Plus – Blue Mt. H2H** **HCPI – Whitman Co. HD** **HCPI/GLI – NE TriCounties HD** **SCO/CTR – Prevention Plus – Okanogan** **ILI – ROPED – Spokane HD (Reservation)** **CLI – Prev. Plus - Columbia Co/BMH2H**	X X X X X 	 X X X X X X

MSM	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
2003 Region 1 cont.	MSM – MSM/IDU (includes incarcerated and people in drug treatment)	CLI, GLI, Outreach, ILI; Social Marketing, Media; CTR/PCRS	**CTR – Prev. Plus – BMH2H** CTR/PCRS – All jurisdictions **SCO/CTR – Prev. Plus – Okanogan HD** **ILI/CTR – Lincoln Co. HD** **HCPI – Whitman Co. HD**	X X X	X X X X X
	Youth (14-24)	GLI, CLI, ILI, Peer; Social Marketing/Media; CTR/PCRS	**CTR – Prev. Plus – Okanogan HD** CTR/PCRS – All jurisdictions GLI – OUT There - Whitman Co. **GLI – Garfield Co. HD** **HCPI/GLI – TriCounties HD**	X X	 X X X X
	People of Color:	Outreach, CLI, GLI, ILI; CTR/PCRS	**CTR – Prev. Plus – Okanogan HD** CTR/PCRS – All jurisdictions **ILI** – ROPED – Spokane HD (Reservation) **HCPI – Whitman Co. HD** **SCO/HCPI – Blue Mt. H2H**	X X X	 X X X
	Non-gay Identified	**CLI, GLI, Outreach, ILI; Soc Mkt, Media; CTR/PCRS**	CTR/PCRS – All jurisdictions **ILI – ROPED – Spokane HD (Reservation)**	X X	X
	Use Alcohol/Drugs	GLI, ILI; CTR/PCRS	CTR/PCRS – All jurisdictions **ILI – ROPED – Spokane HD (Reservation)**	X X	X
	People with STD	Not specified	**Not funded**		
2003 Region 2**	HIV+/partners	PCM, GLI, ILI, CLI (POC); CTR/PCRS; Person @Risk model	CTR/ILI - Know Your Status (Person @Risk model) CTR/PCRS – All jurisdictions	X	 X
	Youth (<24)	GLI, CLI, ILI, Peer; Soc Mkt/Media;CTR/PCRS	**Not funded**		
	Non-identifying	**CLI, GLI, Outreach, ILI; Social Marketing, Media; CTR/PCRS**	CTR/PCRS – All jurisdictions **ILI – Kittitas Co. HD**		X X

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MSM	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
	MSM/IDU	**CLI, GLI, Outreach, ILI; Social Marketing, Media; CTR/PCRS**	**GLI – Let's Chat - Benton-Franklin HD,** **Grant Co. HD, Yakima Co. HD,** **Kittitas Co. HD** **CTR/ILI – Kittitas Co. HD** CTR/PCRS – All jurisdictions		X X X X X
	Engaging in unprotected anal intercourse or multiple partners	**CLI, GLI, Outreach, ILI; Social Marketing, Media; CTR/PCRS**	**HCPI–Hot, Healthy & Keeping It Up** **Kittitas, HD, Benton-Franklin HD,** **Grant HD, Yakima HD** **HCPI – Staying Healthy – Chelan-Douglas** **GLI – Let's Chat – Kittitas Co. HD** **CTR – Benton-Franklin HD, Grant HD,** **Yakima HD, Chelan-Douglas HD** CTR/PCRS – All jurisdictions	X	X X X X X
2003 Region 2 cont	Spanish speakers	Outreach, ILI, CLI, GLI; CTR/PCRS	Media – Radio KDNA – Yakima	X	
2003 Region 3***	HIV+/partners	**PCM, GLI, ILI, CLI (POC); CTR/PCRS; Person @Risk model**	CTR/PCRS – All jurisdictions **PCM – Snohomish HD** **GLI – Snohomish HD**	X X X	X X
	Unprotected anal intercourse or multiple sex partners (including survival sex)	**CLI, GLI, Outreach, ILI; Social Marketing, Media; CTR/PCRS**	**GLI – GLOBE – Snohomish HD** **- QUEST – Snohomish HD** **- Friend to Friend (CLI) – Snohomish** **- Friend to Friend (CLI) – Evergreen** **SCO – Friend to Friend (CLI) – Snohomish** **- Friend to Friend (CLI) – Evergreen** CTR/PCRS – All jurisdictions	X X X X X X	 X X X
	With STD	**CLI, GLI, Outreach, ILI; Social Marketing, Media; CTR/PCRS**	CTR/PCRS – All jurisdictions	X	X
	MSM/IDU	**CLI, GLI, Outreach, ILI; Social Marketing, Media; CTR/PCRS**	CTR/PCRS – All jurisdictions	X	X

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MSM	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
2003 Region 4 ****	HIV+	PCM, GLI, Social Marketing, ILI, CLI	**PCM – Lifelong AIDS Alliance**	X	
			GLI - Positive Power – HAPDEU/UW	X	
			CLI - Gay City		X
			- Lifelong AIDS Alliance		X
			HCPI –Power On (Internet) – HAPDEU		X
	Men of Color	Outreach, GLI, CLI, CTR; (ILI, Media)****	CTR		X
			CLI – Brother to Brother	X	
			- ICHS API MSM	X	
			- POCAAN/EH MSM		X
			- Gay City		X
			HCPI – Power On – HAPDEU/UW		X
	MSM/IDU	Needle Exchange (NEX), CLI, (ILI, Outreach, Media)	NEX		X
			CTR		X
			CLI – Stonewall Recovery Svcs – Project NEON		X
			HCPI – Power On – HAPDEU/UW		
	HIV-/Unknown status	CLI, GLI, Outreach, Social Marketing, ILI, (CTR)	CTR		X
			CLI – Lifelong AIDS Alliance		X
			- Gay City		X
			HCPI – Power On – HAPDEU/UW		X
	Non-gay Identified	**CLI, GLI, Outreach, Social Marketing, ILI, (CTR)**	**CTR**		X
			CLI – Brother to Brother	X	
			- ICHS API MSM	X	
	Youth (Street/POC)	GLI, Outreach, CLI, CTR, (ILI, Social Marketing, Media)	CTR		X
			GLI – Street Smart – Youthcare	X	
			- Street Involved Youth - Youthcare	X	
			HCPI – Power On – HAPDEU/UW		X
			CLI – Gay City		X
	MSM – general	Web Site	CTR		X
			HCPI – Power On – HAPDEU/UW		X
			SCO – Public Health – Seattle&King Co.		X
			Hotline – PH-S&KC		X
			HCPI – Health Ed. – PH-S&KC		X

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MSM	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
2003 Region 5-Kitsap *****	MSM – general (Gay identifying)	CLI, GLI, Outreach, ILI; Social Marketing, Media, CTR/PCRS	**SCO** – OUTKitsap CTR/PCRS	X X	X X
	HIV+/partners and friends	PCM, CTR/PCRS	PCM –Kitsap HD Case Management CTR/PCRS	X X	X X
	Young MSM (16-24)	GLI	RFP	X	X
2003 Region 5-Pierce *****	African American	**CTR/PCRS** **GLI -Brother to Brother (Sociometic)** **CLI -Brother to Brother Down Low** **BarberShop Project**	CTR/PCRS **RFP – Brother to Brother (Sociometric)** **Not Funded**	 X	X
	MSM/IDU	**CLI – Community Promise, Project NEON** NEX CTR/PCRS	**CLI – Community Promise - TUL** **Project NEON not funded** NEX CTR/PCRS	 X	X X
	Youth (14-24)	**Mpowerment,** CLI, CTR/PCRS	**RFP – GLI - MPowerment** CLI - OASIS – PCAF Youth Peer Ed Program - TPCHD CTR/PCRS	X	
2003 Region 6 ******	**HIV+**	**PCM,** CTR/PCRS	**PCM – RFP** CTR/PCRS – All jurisdictions	X X	 X
	Youth	**GLI, CLI,** CTR/PCRS), **(SCO – not prioritized)**	**GLI – Stonewall Youth – Thurston** **GLI – Mason (GLBTQ, POP)** CTR/PCRS – All jurisdictions	X X	 X X
	HIV + partner	**GLI, CLI,** CTR/PCRS	CTR/PCRS – All jurisdictions	X	X
	(MSM)/IDU	NEX, **GLI,** CTR/PCRS. **(SCO – not prioritized)**	NEX/**SCO** – Several jurisdictions **GLI/SCO – Clark Co. Meth Projects** CTR/PCRS – All jurisdiction	 X X	X X X

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MSM	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
2003 Region 6 cont	**Male POC**	**GLI, CLI,** CTR/PCRS, **(SCO – not prioritixed)**	**GLI/SCO – Mpowerment – Thurston HD** **SCO – Lewis Co. HD** CTR/PCRS – All jurisdictions	X X	 X X
	Multiple Sex Partners	**GLI, CLI,** CTR/PCRS, **(SCO – not prioritized)**	**GLI – Clallam Co. HD** **GLI – Mpowerment – Thurston HD** **GLI/SCO – Lewis Co. HD** **SCO – Cowlitz Co. HD** CTR/PCRS – All jurisdictions	X X X X	X X X X
	Non ID	**CLI, GLI,** CTR/PCRS	**GLI – Clallam Co. HD** CTR/PCRS – All jurisdictions	X X	 X
	Survival Sex	**CLI, GLI,** CTR/PCRS	CTR/PCRS – All jurisdictions	X	X

* Region 1 – Prioritized populations (behavioral risk) and began effective interventions prioritization process

** Region 2 – Continued review of prioritized populations (behavioral risk) and prioritized effective interventions

*** Region 3 – Prioritized populations (behavioral risk) and began effective interventions prioritization process

**** Region 4 – Recommended interventions in parentheses acceptable. RFP contractors/interventions identified in 2002 and continued in 2003

***** Region 5 – Kitsap – no significant changes. Pierce – Prioritized populations (behavioral risk) and effective interventions

****** Region 6 – Completed prioritization of populations, partially completed prioritization of effective interventions. MSM is SECOND priority category

2003 Updated PRIORITIZED POPULATIONS, INTERVENTIONS AND FUNDING BY REGION. The following table reflects the information for 2003. Changes are noted in bold type. Because prioritization is an on-going process, changes in one area may not be reflected in another until the following year, i.e. a change in the prioritized populations may take at least one year to be reflected in new interventions.

IDU	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
2003 Region 1	**General**	NEX, Outreach, GLI, CLI, CTR/PCRS	**SCO – Prevention Plus – Okanogan HD**	X	X
			- Blue Mt. H2H		X
			HCPI – NETri HD, Blue Mt. Heart 2 Heart		X
			CTR/PCRS – All jurisdictions	X	X
	Needle sharing	Needle Exchange, Outreach	NEX – provided in several jurisdictions		X
			CTR/PCRS – All jurisdictions	X	X
	Youth (14-24)	NEX, GLI, CLI, ILI, Peer; Social Marketing/Media; CTR/PCRS	**GLI – Garfield HD**		X
			ILI – NETri HD		X
			HCPI – NETri HD, Whitman HD		X
			SCO – Prevention Plus – Okanogan HD	X	X
			CTR/PCRS – All jurisdictions	X	X
	People of Color: Hispanic/Latino	**NEX, GLI, CLI, ILI, Peer; Social Marketing/Media; CTR/PCRS**	CTR/PCRS – All jurisdictions	X	X
	Incarcerated	**GLI, CLI, ILI, Peer; Social Marketing/Media; CTR/PCRS**	**SCO – Okanogan HD**	X	X
			ILI – Lincoln HD, Okanogan HD	X	X
			CTR/PCRS – All jurisdictions	X	X
	Drug Treatment	**GLI, CLI, ILI, Peer; Social Marketing/Media; CTR/PCRS**	**HCPI – Spokane HD, Lincoln HD**	X	X
			CTR/PCRS - All jurisdictions	X	X
	With STD	**NEX, GLI, CLI, ILI, Peer; Social Marketing/Media; CTR/PCRS**	**Not Funded**		
2003 Region 2	IDU – general	Needle Exchange, Outreach, ILI, GLI, CLI, CTR/PCRS, Person @Risk model	NEX provided in several jurisdictions		X
			Outreach provided in several jurisdictions		X
			CTR/ILI - Persons @ Risk model – Yakima		X
			CTR/PCRS – All jurisdictions		X
	Drug Treatment	**Outreach, ILI, GLI, CLI, CTR/PCRS**	**GLI – Project SMART (Socio) – Kittitas HD, Grant Co. HD, Yakima HD**		X
			CTR/PCRS – All jurisdictions		X

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IDU	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
2003 Region 2 cont	**Multiple Sex Partners**	**Needle Exchange, Outreach, ILI, GLI, CLI, CTR/PCRS, Person @Risk model**	NEX provided in several jurisdictions CTR/PCRS – All jurisdictions **GLI – Let's Chat (Socio) – Kittitas HD, Grant Co. HD, Yakima HD** **- Hot, Healthy and Keeping It Up (Socio) – Benton-Franklin HD**		X X X X
	Incarcerated	**Outreach, ILI, GLI, CLI, CTR/PCRS**	CTR/PCRS – All jurisdictions		X
	Latino	NEX, **GLI, ILI, Social Mrktg/Media**	**Media – Radio KDNA**	X	
2003 Region 3	HIV+/partners	**NEX, PCM**	NEX **PCM**	 X	X X
	Multiple Sex Partners	**Needle Exchange, Outreach, ILI, GLI, CLI, CTR/PCRS**	**NEX** **HCPI – Snohomish HD** CTR/PCRS – All jurisdictions	 X X	X X X
	Incarcerated IDU	Outreach, ILI, GLI, CLI, CTR/PCRS	CTR/PCRS – All jurisdictions **HCPI – Snohomish HD**	X X	X X
	With STD	**Needle Exchange, Outreach, ILI, GLI, CLI, CTR/PCRS**	**NEX** CTR/PCRS – All jurisdictions	 X	X X
2003 Region 4	Homeless/Involved with legal system	Needle Exchange, Outreach, GLI, CTR, (Methadone, PCM)****	NEX – **PH-S&KC** CTR - **PH-S&KC** **Methadone Vouchers – PH-S&KC** **SCO – Street Outreach Services (SOS)**		X X X X
	Women – survival sex	Needle Exchange, Outreach, CTR, (GLI, Methadone)	NEX - **PH-S&KC** CTR - **PH-S&KC** **Methadone Vouchers – PH-S&KC** **CO – Street Outreach Services (SOS)**		X X X X

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IDU	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
2003 Region 4 cont	Youth <25 or new injectors <3 years	Needle Exchange, Outreach, CTR, (GLI, Methadone)	NEX - **PH-S&KC** CTR - **PH-S&KC** **Methadone Vouchers – PH-S&KC** **CO – Street Outreach Services (SOS)**		X X X X
	HIV+ or HCV+	Needle Exchange, PCM, GLI, ILI, CTR, (Methadone)	NEX - **PH-S&KC** CTR - **PH-S&KC** **Methadone Vouchers – PH-S&KC**		X X X
	General (not a NEW priority, reflects SHARE information)	Needle Exchange, PCM, GLI, ILI, CTR, (Methadone)	NEX – PH-S&KC Hotline – PH-S&KC Clearinghouse – PH-S&KC CTR – PH-S&KC Condom Distribution – PH-S&KC HCPI – PH-S&KC		X X X X X X
2003 Region 5-Kitsap	Heroin Users	Needle Exchange, Syringe Access, Treatment referral, CTR/PCRS	**NEX** Syringe Access program		X X
	HIV+/partners	PCM, Needle Exchange, (Syringe Access), Treatment referral, CTR/PCRS	PCM **NEX** Syringe Access program CTR/PCRS	X	 X X X
	Methamphetamine	PCM, Needle Exchange, (Syringe Access), Treatment referral, CTR/PCRS	PCM **NEX** Syringe Access CTR/PCRS Referral to Project NEON	X	 X X X

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IDU	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
2003 Region 5-Pierce	African Americans	**NEX, CLI, GLI, CTR/PCRS**	NEX – **PDAP/TPCHD**		X
			HCPI – From Me to You - TUL	X	
			CTR/PCRS	X	X
	HIV+/partners	**NEX, PCM, CLI, ILI, GLI, CTR/PCRS**	NEX – **PDAP/TPCHD**		X
			PCM	X	X
			CTR/PCRS	X	X
			ILI -Early Intervention Case Management		X
	Homeless	**NEX, CLI, GLI, CTR/PCRS**	NEX – **PDAP/TPCHD**		X
			CTR/PCRS	X	X
	Incarcerated	**NEX, CLI, GLI, CTR/PCRS**	CTR/PCRS	X	X
	Latino/a	**NEX, CLI, GLI, CTR/PCRS**	NEX – **PDAP/TPCHD**		X
			CTR/PCRS	X	X
			HCPI – From Me to You – TUL	X	
	Youth	**NEX, CLI, GLI, CTR/PCRS**	NEX		X
			CTR/PCRS	X	X
	General	**NEX, CLI, GLI, CTR/PCRS**	**NEX – PDAP/TPCHD**		X
2003 Region 6	IDU-general **& Needle Sharing**	Needle Exchange, CTR, GLI, **Outreach,** access to treatment	NEX provided in several jurisdictions		X
			CTR provided in all jurisdictions	X	X
			GLI – Clallam HD, Cowlitz HD, Lewis HD, Mason HD, Pacific HD		X
			SCO – Clallam HD, Clark HD, Cowlitz HD, Grays Harbor HD, Jefferson HD, Lewis HD		X
			HCPI – Thurston Co. HD		X
			PCM – RFP	X	

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Hetero-sexual	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
Region 1*	HIV+/partners	PCM, GLI, ILI, CLI (POC); CTR/PCRS; Person @Risk model	PCM – Milestones CTR/PCRS – All jurisdictions Persons @Risk model	 X X	X X
	Youth – General Pop	HCPI, CTR/PCRS;	School based Education – All jurisdictions CTR/PCRS – All jurisdictions	 X	X X
	Multiple sex partners or partners of HIV+ or persons at risk	PCM, GLI, ILI, CLI (POC); CTR/PCRS; Person @Risk model	CTR/PCRS – All jurisdictions HCPI – All jurisdictions, especially in jail and drug treatment settings	X	X X
Region 2	HIV+/partners	PCM, GLI, ILI, CLI (POC); CTR/PCRS; Person @Risk model	CTR/PCRS – All jurisdictions Persons @Risk model	X X	X
	People of Color – Hispanic/Latino	ILI, GLI, Outreach, CTR/PCRS, Media	GLI – provided by several jurisdictions Media – Radio KDNA – Yakima	X X	X X
	With STD	ILI, GLI, Outreach, CTR/PCRS	**HCPI – Doing Something Different Spcio) Chelan-Douglas HD, Kittitas HD**		 X
	General Population	None	CTR/PCRS – All jurisdictions		X
Region 3	HIV+/partners	PCM, GLI, ILI, CTR/PCRS	CTR/PCRS – All jurisdictions **PCM – Snohomish HD**	X X	X X
	With STD	**GLI, ILI, CTR/PCRS**	CTR/PCRS – All jurisdictions **Targeted STD – Whatcom HD**	X X	X X
	Women/partners of at risk males	**GLI, ILI, CTR/PCRS**	CTR/PCRS – All jurisdictions	X	X
Region 4	Female partners of high risk males	GLI, ILI, Outreach (sex industry), Social Marketing, CLI, CTR	CTR **SCO – SOS**		X X
	People with STD's/esp. POC	GLI, ILI, CLI, CTR	CTR **CLI – POCAAN Het/STD** **CLI – Lifelong AIDS Alliance** **GLI – Youthcare**	 X X X	X
	Youth	GLI, ILI, Outreach (sex industry), Social Marketing, CLI, CTR	CTR **CLI – Lifelong AIDS Alliance** **CLI – POCAAN Het/STD** **GLI – StreetSmart – Youthcare**	 X X X	X

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Hetero-sexual	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
Region 5-Kitsap	Partners of HIV+	PCM, GLI, CTR/PCRS	PCM CTR/PCRS	X X	X X
Region 5-Pierce	**HIV+/partners**	**PCM, CLI, ILI, GLI, CTR/PCRS**	**PCM** Early Intervention Program		X X
	African American Women	**CLI, ILI, GLI, CTR/PCRS**	CTR/PCRS HCPI – From Me to You – TUL	X X	X X
	Latino/a	**CLI, ILI, GLI, CTR/PCRS**	CTR/PCRS HCPI – From Me to You – TUL CLI – Latino Project – Good Samaritan	X X	X X
Region 6	HIV+/partners	PCM, couples counseling, CTR/PCRS	**PCM - RFP** CTR/PCRS – All jurisdictions	X X	 X
	Female partners of MSM or IDU	PCM, CTR/PCRS	**PCM – RFP** CTR/PCRS – All jurisdictions **SCO – Thurston HD**	X X	 X X
	Multiple Sex Partners	**CLI, ILI, GLI, CTR/PCRS**	CTR/PCRS – All jurisdictions **GLI – Clallam HD, Grays Harbor HD, Lewis HD, Mason HD, Pacific HD, Stonewall Youth** **HCPI – Cowlitz HD, Thurston HD** **SCO – Clallam HD, Cowlitz HD**	X X	X X X X
	People of Color	Peer GLI	CTR/PCRS – All jurisdictions **GLI/SCO – Lewis HD –Latino Intervention**	X	X X
	Survival sex	Peer Outreach	Not funded		

*Region 1 did not prioritize Heterosexual as a separate risk category, but included it as 'partners' in the other categories.

Other	Populations	Recommended Effective Intervention Types	Actual Interventions Funded	Federal	State/Other
Region 3	Hispanic	Not specified	Outreach – **Skagit Summer Migrant** HC/PI – Whatcom Hispanic & Migrant		X X
Region 4	Transgender	To be determined by Needs Assessment	Lifelong AIDS Alliance – Needs Assessment RFP – Intervention	X X	

2003 UPDATE – Glossary for Table 19

INTERVENTION TYPES:

CLI – Community-level Intervention

CTR – Counseling, Testing and Referral Services
CTR/PCRS – Counseling, Testing and Referral Services linked with Partner Counseling Referral Services

GLI – Group-level intervention

HCPI – Health Communications and Public Information

ILI – Individual-level Intervention

NEX – Needle Exchange Program

PCM – Prevention Case Management

SCO – Street and Community Outreach

OTHER ABBREVIATIONS:

Access to Tx – development of collaborations, agreements and other means to enhance or assure access to substance abuse treatment.

BMH2H – Blue Mountain Heart to Heart – ASO in Walla Walla serving southeast Washington in Region 1.

EAF – Evergreen AIDS Foundation. AIDS service organization (ASO) in Bellingham, Region 3.

Early Intervention Case Management – Case management related prevention intervention for HIV+ in Pierce county, Region 5.

F2F – Friend to Friend. A community level intervention for MSM based on the popular opinion leader model of Jeff Kelly, et al.

GLOBE – Gay, Lesbian, Open-minded. Bisexual Empowerment. A youth empowerment program in Snohomish County, Region 3.

HAPDEU/UW – HIV AIDS Project Development and Evaluation Unit, University of Washington. Research and ASO. Provides statewide services.

HCV+ - a person who has been diagnosed with Hepatitis C.

HD – Health Department or Health District

HIV- - A person who has been diagnosed as not being HIV infected through a negative HIV-antibody test.

HIV+ - a person who has been diagnosed with HIV disease through a positive HIV antibody test.

ICHS API/MSM – International Community Health Services, Asian/Pacific Islander/Men who have sex with men project. Region 4.

IDU – Injection drug user. A person who is practicing behaviors that include injecting legal and illegal substances intravenously, intramuscularly and subcutaneously.

LHJ – local health jurisdictions, may consist of more than one county health department.

MSM – Men who have sex with men. A person who are sexually involved with other men, even if they do not identify with being termed gay or bisexual.

MSM/IDU – a person who practices behaviors as both an MSM and IDU that put them at risk for HIV transmission. Interventions targeted to this group must address both sets of behaviors equally.

NETri – NE Tri-counties Health District. Ferry, Stevens and Pend Orielle Counties, Region 1.

NEX – Needle (Syringe) Exchange. An intervention that provides sterile injection equipment in exchange for used equipment.

Non ID - a male who does not identify as gay, but participates in male to male sexual activity.

Not specified – an effective intervention recommendation either not identified or included in the regional HIV prevention plan.

PCAF – Pierce County AIDS Foundation. ASO in Pierce County, Region 5.

PDAP – Point Defiance AIDS Project. ASO in Pierce County, Region 5.

Person @Risk model – a pilot project in Regions 1 and 2 to explore the use of a CTR/PCRS intervention developed by Dr. W. Jordan at Oasis Clinic in Los Angeles.

PH-S&KC – Public Health – Seattle & King County. Region 4.

POC – people of color.

POCAAN – People of Color Against AIDS Network. A Seattle ASO that provides services to communities of color in Regions 2, 4 and 5

POCAAN/EH MSM – POCAAN/Entre Hermanos Men who have sex with men Project. Region 4.

Project Neon – A program in Region 4 specifically targeting Methamphetamine MSM.

Radio KDNA – a local radio and TV station in Region 2 serving the Spanish speaking communities in Yakima and surrounding communities.

RFP – Request for Proposal or Program. A process by which a contractor calls for bids to provide a specific intervention. A process utilized in all regions. A listing of RFP in the table indicates that the RFP process has been identified, but the contractor has not yet been selected. For updated information on these interventions, contact the regional coordinator or DOH.

ROPED – Reservation Outreach and Peer Education Development. An intervention in Region 1 targeting American Indians on tribal land.

SAN – Spokane AIDS Network. An ASO in Spokane, Region 1.

STD – sexually transmitted disease

TPCHD – Tacoma-Pierce Co. Health Department, Region 5

TRC – Triangle Recreation Camp. A gay men's annual summer gathering in Snohomish county, Region 3.

TUL – Tacoma Urban League. A community-based organization (CBO) in Pierce county, Region 5, serving African Americans and other communities of color.

Unknown serostatus – a person who practices behaviors that might put them at risk for HIV transmission, but has not tested for HIV antibodies or has not revealed any test results.

TABLE 9 (Repeat of page 24)
PRIORITIZED EFFECTIVE INTERVENTION TYPES BY BEHAVIORAL RISK CATEGORY

	HERR	HC/PI	CTR/PCRS	PCM
1	Groups Individual Level		Targeted CTR PCRS "Person @risk"	PCM
2	Community Level Intervention (Communities of color)	Social Marketing Mass Media & Other Media		
3		Hotline/Clearinghouse		

MSM - Urban and Rural

	HERR	HC/PI	CTR/PCRS
1	Community level Interventions Group level Interventions		CTR-high risk PCRS
2	Street/Community Outreach Individual level Interventions	Social Marketing Mass Media & Other Media	
3		Hotline/Clearinghouse	

IDU - Urban and Rural

	HERR	HC/PI	CTR/PCRS
1	Needle Exchange Community level Interventions		CTR-high risk PCRS
2	Individual level Interventions Street/Community Outreach		
3	Group level Interventions	Mass Media & Other Media Social Marketing Hotline/Clearinghouse	

HETEROSEXUAL - Urban

	HERR	HC/PI	CTR/PCRS
1	Community level Interventions Group level Interventions Street/Community Outreach		CTR-high risk PCRS
2	Individual level Interventions	Mass Media & Other Media Social Marketing	
3		Hotline/Clearinghouse	

HETEROSEXUAL - Rural

	HERR	HC/PI	CTR/PCRS
1	Community level Interventions Group level Interventions	Mass Media & Other Media Social Marketing	CTR- high risk PCRS
2	Individual level Interventions Street/Community Outreach		
3		Hotline/Clearinghouse	

For a complete explanation of abbreviations see pages 71-72 (4/26/01)

TABLE 20 - INTERVENTION TYPES

INTERVENTION	INCLUDES	EXCLUDES
A. Individual Level Intervention (ILI)	Health education and risk reduction intervention provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services.	Excludes outreach or prevention case management. Each constitute their own intervention category.
B. Group Level Intervention (GLI)	Health education and risk reduction intervention (see above) that shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide range of skills, information, education, and support (DOH has added the requirement that the GLI must be multiple sessions).	Excludes group education that lacks a skills component and or is a single session. Those types of activities should be included in the Health Communication/Public Information category.
C. Outreach	HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients' typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials.	Excludes condom or material drop offs and other outreach activities that lack face-to-face contact with a client.
D. Prevention Case Management (PCM)	Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.	Excludes one-to-one counseling that lacks ongoing and individualized prevention counseling, support, and service brokerage.
E. Partner Counseling and Referral Services (PCRS)	A systematic approach to notify sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.	Excludes HIV counseling and testing which is reported in its own category using the standard bubble sheets.
F. Health Communication/ Public Information (HC/PI)	The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behaviors, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. **Electronic Media**: Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city, region, or statewide) audience. **Print Media:** These formats also reach a large-scale or nationwide audience; includes any printed material, such as newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage.	Excludes group interventions with a skills building component, which constitutes its own intervention category.

INTERVENTION	INCLUDES	EXCLUDES
	Hotline: Telephone service (local or toll free) offering up-to-date information and referral to local services, e.g., counseling/testing and support services. **Clearinghouse:** Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide responsive information service to the general public as well as high-risk populations. **Presentations/Lectures:** These are information-only activities conducted in-group settings; often called "one-shot" education interventions. **Social Marketing:** Uses techniques adapted from commercial marketing to identify specific audiences called segments and their perceived needs, and then constructs a program of services, support, and communication to meet those needs.	
G. Counseling, Testing and Referral (CTR)	An individualized intervention of usually two session (pre-test and post-test) aimed at learning current serostatus; increasing understanding of HIV infection; assessing risk of HIV acquisition and transmission; negotiating behavior change to reduce risk of acquiring or transmitting HIV; and, providing referrals for additional medical, preventive and psychosocial needs. HIV counseling and testing is more than an information session; however, it is not therapy. This intervention is closely linked to Partner Counseling and Referral Services (PCRS).	Excludes PCRS which is reported in its own category using the standard reporting forms.
Other Interventions	Category to be used for those interventions funded with CDC Announcement 99004 funds that cannot be described by the definitions provided for the other seven types of interventions (example forms A-G). This category included community level interventions (CLI). CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilization, social marketing campaigns, community-wide events, policy interventions, and structural interventions.	Excludes any intervention that can be described by one of the existing categories.

NEEDS ASSESSMENTS

Throughout 2002-2003, each region will be conducting target population needs assessments that are appropriate to complete the gap analysis and planning. The data from these assessments will determine what changes will be made in the priority populations and interventions. DOH is developing tools and procedures that can be used to do these assessments in a systematic and appropriate way.

On a statewide basis, the set-aside priorities have identified an assessment of young gay men of color. There will also be a follow-up on the American Indian assessment, with consultation and technical assistance from national experts. The findings of the seasonal farm worker needs assessment will determine the priority interventions throughout the state.

2003 UPDATE

With the guidance of the Institutional Review Board, policies and procedures for implementing needs assessments (Priority Population Assessments) were established, new SPG guidance was developed and manuals for focus group and key informant interviews were written. (Attachments 3A and 3B, 2003 UPDATE)

2003 UPDATE - OUTCOME MONITORING

By the end of 2001, the project to identify and develop methodologies and tools for outcome monitoring of health education and risk reduction (HERR) individual and group level interventions was completed. An Outcome Monitoring Tool for group and individual level interventions has been developed and is a testing phase. It is anticipated that full implementation of utilization of this tool will happen mid-2003.

2003 UPDATE - OUTCOME EVALUATION

The multi-year project to evaluate the Friend to Friend Project will be in its final year. A great deal of information has already been summarized about MSM behaviors, needs and activities. This information will be available to the planning groups for their next cycle of planning.

The prevention case management programs will meet in late 2002 to develop clear programmatic and service definitions, determine recommendations for standards of service and develop evaluation and outcome monitoring methods. These findings will provide the foundation to PCM services in Washington state.

PILOT PROJECTS

PERSON @RISK Model (Know Your Status):
With Dr. Wilbert Jordan as consultant and an outside evaluator, the prevention and care providers identified in Regions 1 and 2 will design, implement and monitor outcomes of an adaptation of the L.A. Oasis Clinic model for rural, individual interventions with high-risk individuals. (*Journal of the National Medical Association* 1998; Vol. 90, No. 9, pages 542-546). The intervention design utilizes incentives to identified HIV+ people to

facilitate identification of people they think are at risk for HIV infection. Those people identified are then asked to participate in an incentive educational program that provides the opportunity for HIV antibody testing. This intervention (as a group process) resulted in increased identification of HIV+ people in hard to reach communities. It is anticipated that the same results (on a much smaller scale) will be seen on an individual basis in rural areas.

SEASONAL FARM WORKER COORDINATION PROJECT

As part of the needs assessment of seasonal farm workers in Washington, the migratory patterns will be explored. From this information, a network of the outreach workers across the state will meet to discuss and design a coordination process for HIV education and outreach to seasonal farm workers. The outcome of this project should be increased numbers of seasonal farm workers who self-identify as high-risk and, concurrently, an increase in the number of those individuals who know their status and have received risk reduction information.

WHAT

STILL

NEEDS

TO

BE

DONE

2003 UPDATE -WHAT STILL NEEDS TO BE DONE

In the planning process and, consistent with, CDC guidance, each jurisdiction is required to identify the unmet needs of their state or community. As with all decisions, unmet HIV prevention needs in the state of Washington are the result of – or impacted by – several factors or barriers, including legislation and policy, knowledge (assessment and technology) and resource limitations (funding, staffing and service capacity). Each of these factors can contribute to unmet needs. For example, statewide local policies and laws may create barriers to access to new sterile syringes/needles for IDU's, whether through pharmacies or needle exchange programs. Recent legislation and policy decisions have resulted in pharmacy access to clean syringes for the prevention of blood-borne pathogens. Lack of data (especially prevalence and incidence data) contributes to a situation in which the cost-effectiveness of many programs and approaches can only be speculated. "Hard-to-reach" subpopulations (i.e. HIV infected persons who do not know their serostatus, or men who do not identify their sexual activity with other men as significant or relevant to their risk for HIV transmission) remain difficult to plan for and reach. Resource constraints limit the ability of the Department to fund community partners to deliver prevention services or build capacity, especially in rural areas. Staffing limitations at DOH hampers the availability of technical assistance, evaluation and quality assurance.

For most priority populations and interventions, funding limits create unmet needs that are primarily "level of effort" rather than a complete absence of a program or services. As an example, all populations have access to counseling and testing services, but the ability of small health departments to provide specifically targeted services for very small populations is difficult to balance with all of the other demands on that health department. It is very difficult to fund multiple effective interventions to all identified populations, so often one or two programs are funded in hopes of 'catching' the most at-risk people. As a result, all of the populations identified in this plan have unmet needs. In particular, prevention programs for the following subpopulations on a statewide basis have the greatest level of unmet needs. Exclusion or inclusion on this list does not mean that all of the needs are unmet or that there is no effort to reach this population.

STATEMENT OF UNMET NEEDS

Population	Unmet Needs	Barriers/Constraints
HIV-infected persons	Individual, group and community level interventions to establish and maintain safer sex practices	Funding; access and recruitment
Injection Drug Users	Substance Abuse Treatment Access to sterile needles/ syringes	Funding Law and policy (improved)
Female partners of MSM, IDU or person with HIV	Knowledge of at-risk status	Effective strategies that identify these at-risk women. Cost effective interventions

African Americans at-risk	Knowledge of at-risk status Lack of proven community-level interventions	Funding; social/cultural barriers resulting from disenfranchisement and health disparities.
American Indians at-risk	Lack of identified effective interventions	Funding, multiple sovereign nation status; culturally appropriate interventions.
MSM with multiple anonymous partners, especially in public sex environments	Group and community level interventions	Funding; resistance due to community norms and values
Non self-identifying MSM	Acknowledgement of risk behaviors and interventions to identify and promote safer sex practices	Effective interventions research, cultural and language barriers, social norms and values.
Rural populations at-risk	1. Knowledge of at-risk status; 2. Identified effective rural interventions	Cost effective, scientifically proven interventions for rural settings; community norms and values.

Even with identification of these unmet needs on a statewide basis, the ability to meet these needs continues to be limited by lack of identified effective interventions, lack of resources to evaluate presently funded programs and resistance in communities and decision making bodies to implement changes necessary to impact the barriers.

The development of a gap analysis model and guidance may impact some of these issues on a statewide basis. It will have more of an impact on local planning and prevention efforts.

TECHNICAL ASSISTANCE

Regions were asked to identify their technical assistance needs for the next year. These technical assistance needs often reflect the unmet HIV prevention needs or frustrations in the region. The statewide goal of providing technical assistance, training and consultation with each region is the overall response to these needs. Technical assistance may be provided by the region, DOH or national TA providers, depending on the level and extent of the need and resources.

Technical assistance will be available from DOH, or an appropriate provider, in the following areas:

Planning Process

- Effective intervention determination and/or design
- Process and outcome objective development
- Implementation of SPG planning guidance at the RPG level
- Implementation of PIR plans
- Epidemiologic information, state and regional

- Developing target population assessments
- Implementing outcome monitoring
- Defining and prioritizing target populations

Prevention Programs

- Provision and quality assurance of counseling and testing activities in publicly funded sites
- Provision and quality assurance of partner counseling and referral services in publicly funded sites
- Technical Assistance to private providers for partner notification
- Provision and quality assurance of partner elicitation skill for partner notification services
- Confidentiality and security of HIV records (in conjunction with HIV Client Services)
- Development and quality assurance of interventions by governmental and non-governmental agencies and organizations

Data Collection and Program Monitoring

- Participation and utilization of the SHARE (Statewide HIV Activity Reporting and Evaluation) System
- Periodic system refinement and updates

The following are the **2003 UPDATED** technical assistance requests submitted as part of the regional plan:

REGION	Identified TA Needs
1	• Community Resource Inventory development • Cost Effectiveness determination • Program Evaluation • Rural Interventions
2	• Evaluation/outcome monitoring of 'behavioral change' • Program evaluation for 'on-going' interventions in rural areas • Effective rural interventions • Gap analysis and cost effectiveness
3	• Application of needs assessment data, gap analysis and community resource inventory to prioritization process. • Effective interventions • Outcome monitoring
4	No technical assistance needs identified in plan

REGION	Identified TA Needs
5-Kitsap	• Evaluation and outcome monitoring • Effective interventions for rural settings
5-Pierce	• Prioritizing special populations • Interpretation of epidemiologic data • Parity, inclusion, and representation • Evaluation of the planning process • Evaluating HIV prevention strategies • Cost analysis • Gap analysis • Group dynamics/conducting effective meetings
6	• Assistance for Regional Planning Committee, local health jurisdictions and service providers, to ensure that effective, targeted interventions are developed and implemented through the region • Assistance with outcome evaluation (monitoring) • Assistance with needs assessment and gap analysis • Assistance to further develop the community planning process, including a plan to evaluate the process • Assistance to develop more effective methods to link HIV prevention and care services • Assistance to develop additional funding sources for HIV prevention in the region

COMMUNITY PLANNING

Improving the community planning process in all planning groups is a universal goal. Each planning group conducts process evaluations of their planning procedures and products and modifies their by-laws, procedures and policies as needed. Review of the process evaluations included in regional plans reflect a positive process. Where issues were raised, minutes reflect resolution or, at least, discussion. All planning groups are torn between 'takes too much time' and 'there is never enough time to do everything we need to do.' Perhaps the best measure of the success, or stubbornness, of the community planning process is the longevity of service demonstrated on and by the groups. Over 50% of those involved in planning have been listed on at least 3 years of membership lists and over 75% have served for more than 2 years. All of the planning groups provide orientation and support of their members and has been appreciated by those members. All of the members indicated at some point that the process can be overwhelming when you are new or the issues become very complex. Community planning has become progressively more complex over the years and this has contributed to rising levels of frustration with the process. But people 'hang in there' and get through it to participate.

Washington State has participated, for the past 2 years, in the national workgroup to develop a Community Planning Evaluation. This workgroup has completed its initial process and the pilot evaluations began in 2002. Washington State is one of the participants of this pilot evaluation. The sharing of the process and features developed in this national effort has had a great impact on the community plans submitted in 2002. The AIDSNET Coordinators integrated the features list (draft) into the guidance elements of their regional plan format. This has resulted in clearer and more consistent plans and has greatly enhanced the ability to combine the plans into a single statewide Prevention Plan. It is anticipated that as these features become more refined in the national process, that the impact will be even more positive.

LETTERS

OF

CONCURRENCE

State and Regional

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

August 22, 2002

Centers for Disease Control and Prevention
Grants Management Branch, Procurement and Grants Office
Lynn Mercer, Grants Management Officer
Program Announcement 99004
2920 Brandywine Rd., Room 3000, Mail Stop E-15
Atlanta, Georgia 30341-4146

RE: Cooperative Agreement Number U62/CCU002018
Washington State HIV Prevention Project

Dear Ms. Mercer:

As described in the narrative of the 2003 Cooperative Agreement Application, responsibility for assessing and concurring on funding for statewide, identified unmet HIV prevention needs resides with the Washington State HIV Prevention Community Planning Group (SPG). The SPG fulfilled its responsibility after careful review of the 2003 Update and Application.

Members of the SPG reviewed the 2003 HIV Prevention Plan Update and the 2003 Cooperative Agreement Application at the August 22, 2002 meeting. Members were asked to specifically review the Application to determine the extent to which it reflected the prioritized unmet needs and recommended interventions in the Plan.

Members of the SPG were actively involved in all levels of determining the unmet HIV prevention needs for 2003. Members participated in at least one SPG committee that identified or reviewed at-risk populations, effective interventions, and/or unmet prevention needs.

At the August 22, 2002 meeting of the SPG, members unanimously determined, through consensus, that the 2003 Washington State HIV Prevention Cooperative Agreement Application is responsive to the program priorities identified in the comprehensive HIV Prevention Plan for Washington State. The concurrence with the application was without reservation.

Copies of concurrence letters from the regional planning groups (RPG) to the SPG are included in the application.

If there are any questions, please contact John F. Peppert at (360) 236-3427 or by email at john.peppert@doh.wa.gov

Sincerely,

Jack Jourden
Health Department Co-Chair

Dale Briese
Community Co-Chair

Enclosure

cc: Nikki Economou

SPOKANE REGIONAL HEALTH DISTRICT

1101 West College Avenue
Spokane, WA 99201-2095

509.324.1500 | TEL
509.324.1464 | TDD
www.SRHD.org

June 18, 2002

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
PO Box 47844
Olympia WA 98504-7844

RE: 2003 Region I AIDSNET Letter of Concurrence

Dear Jack:

Please be advised that the Region I AIDSNET Planning Group has reviewed the proposed allocation of funds for HIV prevention services in the region. We find that the proposed allocations meet the criteria of utilizing 100% of the Center for Disease Control and Prevention (CDC, federal) funding to target the prioritized populations and effective interventions, as outlined in the Region 2003 HIV Prevention Plan.

Sincerely,

Steven Nuemiller
For Muril Demory, CBO Co-chair

Barry Hilt
Health District Co-chair

Yakima Health District
104 North First Street
Yakima, Washington 98901
Phone (509) 575-4040
Fax (509) 575-7894

July 8, 2002

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 47844
Olympia, WA 98504-7844

Dear Jack:

Please be advised that the Region II Planning Group has reviewed the proposed allocation of funds for HIV prevention services in the region. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention and 50% of the Omnibus (state) funding to target the prioritized populations and effective interventions, as outlined in the Region II 2003 HIV Prevention Plan.

Sincerely,

Deborah Severtson-Coffin
Community Co-chair
Deborah Severtson-Coffin

Wendy J. Doescher
Health Dept. Co-chair
Wendy Doescher, Region II
AIDSNET Coordinator

SNOHOMISH
HEALTH
DISTRICT

REGION 3 AIDS SERVICE NETWORK
3020 Rucker Avenue, Suite 208
Everett, WA 98201-3900
425.339.5211 FAX: 425.339.5253

Healthy Lifestyles, Healthy Communities

June 5, 2002

AUG 19 2002

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 47844
Olympia, WA 98504-7844

Dear Jack:

Please be advised that the Region 3 HIV/AIDS Community Planning Group met on Wednesday, June 5, 2002 and reviewed the currently proposed allocation of funds for HIV prevention services in the region for next year. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention and 50% of the Omnibus (state) funding to target the prioritized populations and effective interventions, as outlined in the Region 3 2003-2005 Region 3 Comprehensive HIV Prevention Plan-Year ONE.

Sincerely,

Stephen Dorn
Community Co-chair

M. Ward Hinds, MD, MPH
Public Health Co-chair

SD/MWH:apw

LETTER 06052002 Concurrence 2003_2005 Plan Yr1

Attachment 12

SEATTLE HIV/AIDS PLANNING COUNCIL

c/o Public Health – Seattle & King County
400 Yesler Way, Third Floor, Seattle, Washington 98104
Phone (206) 296-4527 Fax (206) 205-5281

July 15, 2002

Jack Jourden, Director
Infectious Disease and Reproductive Health Section
Washington State Department of Health
P.O. Box 47844
Olympia, Washington 98504-7844

Dear Jack:

The Seattle HIV/AIDS Planning Council is the community planning body charged with determining the priorities which dictate the expenditure of certain local, state and federal HIV/AIDS care and prevention services funds granted to Public Health – Seattle & King County. The Council serves as the Region IV Prevention Planning Group.

The Council has reviewed the proposed allocation of funds for HIV prevention services in the Region. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention and 50% of the Omnibus (state) funding to target prioritized populations and support effective interventions, as outlined in the Region IV 2003 HIV Prevention Plan.

Please contact Karen Hartfield, HIV Prevention Planner (206-205-8056) should you have any questions about this correspondence.

Sincerely,

Sam Soriano

Sam Soriano, Community Co-chair
Prevention Planning

Bob Wood

Bob Wood, MD, Public Health Co-Chair
Prevention Planning

Bremerton ❖
Kitsap County
Health District

Scott W. Lindquist, MD, MPH, Director
109 Austin Drive
Bremerton, WA 98312
(360) 337-5235
FAX (360) 337-5298

July 15, 2002

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 47844
Olympia, WA 98504-7844

Dear Jack:

Please be advised that the Region V Kitsap County HIV Prevention Planning Group has reviewed the revisions to the Kitsap County Comprehensive HIV Prevention Plan. We are particularly pleased that a recognized syringe exchange program will be implemented.

We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention and 50% of the Omnibus (state) funding to target the prioritized populations and effective interventions, as outlined in the Region V Kitsap County Revised 2002-2004 HIV Prevention Plan.

Sincerely,

Michael Karpin
Community Co-chair

Lenore Morrey
Health District Co-chair

CC: Region V AIDSNet Coordinator

TACOMA-PIERCE COUNTY
HEALTH
DEPARTMENT

Federico Cruz-Uribe, MD, MPH
Director of Health

Governed by a local
Board of Health

•Community Based
•Competitive
•Integrated
•Preventive

June 19, 2002

John Peppert, Manager HIV Prevention & Education
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 4780
7211 Cleanwater Ln., Bldg. 14
Olympia, WA 98504-7844

Dear John:

Please be advised that the **Region V** Planning Group has reviewed the proposed allocation of funds for HIV prevention services in the region. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention and 50% of the Omnibus (state) funding to target the prioritized populations and effective interventions, as outlined in the **Region V 2003-2006 HIV Prevention Plan.**

Sincerely,

Community Co-chair

Health Dept. Co-chair

Region V AIDSNet Coordinator

Printed on 100% recycled paper
3629 South D Street
Tacoma, WA 98418-6813

253/**798-6500**
TDD: 798-6050
800/992-2456

www.healthdept.co.pierce.wa.us

Region VI AIDS Services Network

2000 Ft. Vancouver Way
Vancouver, WA 98663

David Heal, Coordinator (360) 397-8086
Fax (360) 397-8424

May 24, 2002

Jack Jourden, Director
Washington State Department of Health
Infectious Disease and Reproductive Health
P.O. Box 47844
Olympia, WA 98504-7844

Dear Mr. Jourden:

The Region 6 HIV Prevention Planning Committee has reviewed the proposed allocation of CDC funds for HIV prevention services in the region for CY 2003. We find that the proposed allocations meet the criteria of utilizing 100% of the Centers for Disease Control and Prevention funding to target the prioritized populations with effective interventions, as outlined in the Region 6 2002-2004 HIV Prevention Plan.

Sincerely,

Clain Lust
Community Co-chair

David D. Heal M.S.W.
Health Department Co-chair

2003 UPDATE

List of Attachments